

SOLICITATION, OFFER, AND AWARD		1. Caption Health Benefit Plan for District Employees		Page of Pages 1 81	
2. Contract Number	3. Solicitation Number DCBE-2007-R-0049	4. Type of Solicitation <input type="checkbox"/> Sealed Bid (IFB) <input checked="" type="checkbox"/> Sealed Proposals (RFP) <input type="checkbox"/> Sole Source <input type="checkbox"/> Human Care Agreements <input type="checkbox"/> Emergency	5. Date Issued 7/20/2007	6. Type of Market <input checked="" type="checkbox"/> Open <input type="checkbox"/> Set Aside <input type="checkbox"/> Open with Sub-Contracting Set Aside	
7. Issued By: Office of Contracting and Procurement Group IX 441 4th Street, NW, Suite 700 South Washington, DC 20001			8. Address Offer to: Office of Contracting and Procurement Group IX 441 4th Street, NW, Suite 703 South, Bid Counter Washington, DC 20001		

NOTE: In sealed bid solicitations "offer" and offeror" means "bid" and "bidder"

SOLICITATION

9. Sealed offers in original and 5 copies for furnishing the supplies or services in the Schedule will be received at the place specified in Item 8, or if hand carried to the bid counter located at 441 4th Street, NW, Suite 703 South, Bid Counter Washington, DC 20001 until 2:00 PM local time 20-Aug-07
(Hour) (Date)

CAUTION: Late Submissions, Modifications and Withdrawals: See 27 DCMR chapters 15 & 16 as applicable. All offers are subject to all terms & conditions contained in this solicitation.

10. For Information Contact	A. Name Courtney Lattimore	B. Telephone (Area Code) 202 (Number) 724-5037 (Ext)		C. E-mail Address courtney.lattimore@dc.gov
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OFFER

12. In compliance with the above, the undersigned agrees, if this offer is accepted within 150 calendar days from the date for receipt of offers specified above, to furnish any or all items upon which prices are offered at the price set opposite each item, delivered at the designated point(s), within the time specified herein.

13. Discount for Prompt Payment	<input type="checkbox"/> 10 Calendar days %	<input type="checkbox"/> 20 Calendar days %	<input type="checkbox"/> 30 Calendar days %	<input type="checkbox"/> _____ Calendar days %
14. Acknowledgement of Amendments (The offeror acknowledges receipt of amendments to the SOLICITATION):	Amendment Number	Date	Amendment Number	Date

15A. Name and Address of Offeror	16. Name and Title of Person Authorized to Sign Offer/Contract		
15B. Telephone (Area Code) (Number) (Ext)	15 C. Check if remittance address is different from above - Refer to Section G <input type="checkbox"/>	17. Signature	18. Offer Date

AWARD (TO BE COMPLETED BY GOVERNMENT)

19. Accepted as to Items Numbered	20. Amount	21. Accounting and Appropriation
22. Name of Contracting Officer (Type or Print) Gena Johnson Contracting Officer	23. Signature of Contracting Officer (District of Columbia)	24. Award Date



Government of the District of Columbia



Office of Contracting & Procurement

SECTION B: SUPPLIES OR SERVICES

B.1 The Government of the District of Columbia, Office of Contracting and Procurement, on behalf of the Department of Human Resources (the District) is seeking licensed health care insurance provider(s) to administer one or more of the fully insured health benefit plans listed below. Prescription drug coverage administration is included in the health plan. A “licensed health care insurance provider” is defined as an entity that has been granted a Certificate of Authority (COA) to provide health benefits from the D.C. Department of Insurance, Securities and Banking (DISB).

- B.1.1** Preferred Provider Organization (PPO) benefit plan (Plan 1),
- B.1.2** Point of Service (POS) plan or Manage Care Product (Plan 2),
- B.1.3** Health Maintenance Organization (HMO) plan (Plan 3).

B.2 The District contemplates award of requirements type contract(s) based on fixed bi-weekly premium rates per employee. The District may not offer all plan types listed in B.1 above to its employees; however, the District may select more than one (1) vendor for a plan type. The District will pay the Contractor a one-time fixed fee for transition services during the base period.

B.2.1 The effective date of the plans is expected to be January 1, 2008.

B.2.2 The District will purchase its requirements of the services included herein from the Contractor. The estimated enrollment stated herein reflects the best estimates available. The estimate shall not be construed as a representation that the estimated enrollment will be required or ordered, or that conditions affecting requirements will be stable. They shall not be construed to limit the number of participants which may enroll in the plan administered by the Contractor or to relieve the Contractor of its obligation to provide service to plan participants.

B.3 PRICE SCHEDULES

B.3.1 Base Period (Date of Award – December 31, 2008)¹

B.3.1.1 Transition

(A) Contract Line Item Number (CLIN)	(B) Description	(C) Quantity	(D) Unit Price	(E) Extended Price
0001	Transition Services during the start-up period as described in Section C.3.1	1	\$ _____	\$ _____

¹ The Plan Year during the Base Period is expected to begin January 1, 2008.

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B.3.1.2 Plan 1 – Preferred Provider Organization

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
0002AA	Self Only Premium	1,789		
0002AB	Family Premium	1,223		
0002AC	Retiree (Medicare Eligible) Self Only Premium	58		
0002AD	Retiree (Medicare Eligible) Family Premium	40		
0002AE	TCC Self Only Premium	30		
0002AF	TCC Family Premium	80		
TOTAL ESTIMATED ANNUAL AMOUNT				

B.3.1.3 Plan 2 – Point of Service

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
0003AA	Self Only Premium	1,520		
0003AB	Family Premium	2,280		
0003AC	Retiree (pre-Medicare) Self Only Premium	10		
0003AD	Retiree (pre-Medicare) Family Premium	10		
0003AE	Retiree (Medicare Eligible) Self Only Premium	10		
0003AF	Retiree (Medicare Eligible) Family Premium	10		
0003AG	TCC Self Only Premium	20		
0003AH	TCC Family Premium	40		
TOTAL ESTIMATED ANNUAL AMOUNT				

B.3.1.4 Plan 3 – Health Maintenance Organization

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
0004AA	Self Only Premium	4,073		
0004AB	Family Premium	5,665		
0004AC	Retiree (pre-Medicare) Self Only Premium	68		
0004AD	Retiree (pre-Medicare) Family Premium	115		
0004AE	Retiree (Medicare Eligible) Self Only Premium	37		
0004AF	Retiree (Medicare Eligible) Family Premium	63		
0004AG	TCC Self Only Premium	40		
0004AH	TCC Family Premium	80		
TOTAL ESTIMATED ANNUAL AMOUNT				

B.3.2 Option Year 1 (January 1, 2009 – December 31, 2009)

B.3.2.2 Plan 1 – Preferred Provider Organization

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
1002AA	Self Only Premium	1,789		
1002AB	Family Premium	1,223		
1002AC	Retiree (Medicare Eligible) Self Only Premium	58		
1002AD	Retiree (Medicare Eligible) Family Premium	40		
1002AE	TCC Self Only Premium	30		
1002AF	TCC Family Premium	80		
TOTAL ESTIMATED ANNUAL AMOUNT				

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 Health Insurance Plan for District Employees

B.3.2.3 Plan 2 – Point of Service

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
1003AA	Self Only Premium	1,520		
1003AB	Family Premium	2,280		
1003AC	Retiree (pre-Medicare) Self Only Premium	10		
1003AD	Retiree (pre-Medicare) Family Premium	10		
1003AE	Retiree (Medicare Eligible) Self Only Premium	10		
1003AF	Retiree (Medicare Eligible) Family Premium	10		
1003AG	TCC Self Only Premium	20		
1003AH	TCC Family Premium	40		
TOTAL ESTIMATED ANNUAL AMOUNT				

B.3.2.4 Plan 3 – Health Maintenance Organization

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
1004AA	Self Only Premium	4,073		
1004AB	Family Premium	5,665		
1004AC	Retiree (pre-Medicare) Self Only Premium	68		
1004AD	Retiree (pre-Medicare) Family Premium	115		
1004AE	Retiree (Medicare Eligible) Self Only Premium	37		
1004AF	Retiree (Medicare Eligible) Family Premium	63		
1004AG	TCC Self Only Premium	40		
1004AH	TCC Family Premium	80		
TOTAL ESTIMATED ANNUAL AMOUNT				

B.3.3 Option Year 2 (January 1, 2010 – December 31, 2010)

B.3.3.2 Plan 1 – Preferred Provider Organization

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
2002AA	Self Only Premium	1,789		
2002AB	Family Premium	1,223		
2002AC	Retiree (Medicare Eligible) Self Only Premium	58		
2002AD	Retiree (Medicare Eligible) Family Premium	40		
2002AE	TCC Self Only Premium	30		
2002AF	TCC Family Premium	80		
TOTAL ESTIMATED ANNUAL AMOUNT				

B.3.3.3 Plan 2 – Point of Service

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
2003AA	Self Only Premium	1,520		
2003AB	Family Premium	2,280		
2003AC	Retiree (pre-Medicare) Self Only Premium	10		
2003AD	Retiree (pre-Medicare) Family Premium	10		
2003AE	Retiree (Medicare Eligible) Self Only Premium	10		
2003AF	Retiree (Medicare Eligible) Family Premium	10		
2003AG	TCC Self Only Premium	20		
2003AH	TCC Family Premium	40		
TOTAL ESTIMATED ANNUAL AMOUNT				

B.3.3.4 Plan 3 – Health Maintenance Organization

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
2004AA	Self Only Premium	4,073		
2004AB	Family Premium	5,665		
2004AC	Retiree (pre-Medicare) Self Only Premium	68		
2004AD	Retiree (pre-Medicare) Family Premium	115		
2004AE	Retiree (Medicare Eligible) Self Only Premium	37		
2004AF	Retiree (Medicare Eligible) Family Premium	63		
2004AG	TCC Self Only Premium	40		
2004AH	TCC Family Premium	80		
TOTAL ESTIMATED ANNUAL AMOUNT				

B.3.4 Option Year 3 (January 1, 2011 – December 31, 2011)

B.3.4.2 Plan 1 – Preferred Provider Organization

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
3002AA	Self Only Premium	1,789		
3002AB	Family Premium	1,223		
3002AC	Retiree (Medicare Eligible) Self Only Premium	58		
3002AD	Retiree (Medicare Eligible) Family Premium	40		
3002AE	TCC Self Only Premium	30		
3002AF	TCC Family Premium	80		
TOTAL ESTIMATED ANNUAL AMOUNT				

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B.3.4.3 Plan 2 – Point of Service

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
3003AA	Self Only Premium	1,520		
3003AB	Family Premium	2,280		
3003AC	Retiree (pre-Medicare) Self Only Premium	10		
3003AD	Retiree (pre-Medicare) Family Premium	10		
3003AE	Retiree (Medicare Eligible) Self Only Premium	10		
3003AF	Retiree (Medicare Eligible) Family Premium	10		
3003AG	TCC Self Only Premium	20		
3003AH	TCC Family Premium	40		
TOTAL ESTIMATED ANNUAL AMOUNT				

B.3.4.4 Plan 3 – Health Maintenance Organization

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
3004AA	Self Only Premium	4,073		
3004AB	Family Premium	5,665		
3004AC	Retiree (pre-Medicare) Self Only Premium	68		
3004AD	Retiree (pre-Medicare) Family Premium	115		
3004AE	Retiree (Medicare Eligible) Self Only Premium	37		
3004AF	Retiree (Medicare Eligible) Family Premium	63		
3004AG	TCC Self Only Premium	40		
3004AH	TCC Family Premium	80		
TOTAL ESTIMATED ANNUAL AMOUNT				

B.3.5 Option Year 4 (January 1, 2012 – December 31, 2012)

B.3.5.2 Plan 1 – Preferred Provider Organization

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
4002AA	Self Only Premium	1,789		
4002AB	Family Premium	1,223		
4002AC	Retiree (Medicare Eligible) Self Only Premium	58		
4002AD	Retiree (Medicare Eligible) Family Premium	40		
4002AE	TCC Self Only Premium	30		
4002AF	TCC Family Premium	80		
TOTAL ESTIMATED ANNUAL AMOUNT				

B.3.5.3 Plan 2 – Point of Service

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
4003AA	Self Only Premium	1,520		
4003AB	Family Premium	2,280		
4003AC	Retiree (pre-Medicare) Self Only Premium	10		
4003AD	Retiree (pre-Medicare) Family Premium	10		
4003AE	Retiree (Medicare Eligible) Self Only Premium	10		
4003AF	Retiree (Medicare Eligible) Family Premium	10		
4003AG	TCC Self Only Premium	20		
4003AH	TCC Family Premium	40		
TOTAL ESTIMATED ANNUAL AMOUNT				

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B.3.5.4 Plan 3 – Health Maintenance Organization

(A) Contract Line Item Number (CLIN)	(B) Coverage Type	(C) Estimated Enrollment Quantity	(D) Bi-Weekly Rate per enrollee	(E) Estimated Annual Price (C x D x 26)
4004AA	Self Only Premium	4,073		
4004AB	Family Premium	5,665		
4004AC	Retiree (pre-Medicare) Self Only Premium	68		
4004AD	Retiree (pre-Medicare) Family Premium	115		
4004AE	Retiree (Medicare Eligible) Self Only Premium	37		
4004AF	Retiree (Medicare Eligible) Family Premium	63		
4004AG	TCC Self Only Premium	40		
4004AH	TCC Family Premium	80		
TOTAL ESTIMATED ANNUAL AMOUNT				

SECTION C: SPECIFICATIONS/WORK STATEMENT

C.1 SCOPE

The Government of the District of Columbia, Office of Contracting and Procurement, on behalf of the Department of Human Resources (DCHR) (the District) is seeking licensed health care insurance provider(s) to provide health insurance benefit plans for employees of the District of Columbia government and their eligible dependents, who were first hired on or after October 1, 1987 and temporary continuation of coverage (TCC) participants and retirees.

It is anticipated that employees will be able to choose from a menu of health benefit plans which may include preferred provider organization (PPO) plan, a health maintenance organizations plan (HMO), or point of service (POS) plan.

C.1.1 APPLICABLE DOCUMENTS

Services rendered under the contract shall be provided in accordance with the following applicable documents.

Item No.	Title	Date	Location
1	District Personnel Manual, D.C. Department of Human Resources	As amended	http://www.dchr.dc.gov/dcop/cwp/view,a,1218,q,529259.asp
2	U.S. Office of Personnel Management CSRS and FERS Handbook	19 April 2000	http://www.opm.gov/asd/htm/hod.htm
3	Health Insurance Portability and Accountability Act (HIPAA)	1996, as amended	http://www.cms.hhs.gov/HIPAAGenInfo/
4	D.C. Official Code	2001 ed.	§ 1-621.02 et seq. Health Benefits

C.1.2 DEFINITIONS

C.1.2.1 Annuitant: An employee first employed by the District after September 30, 1987, who has subsequently retired or separated pursuant to the following:

- a) Teachers Retirement Section (D.C. Code, 2001 ed., §§ 38-2001 to 38-2023.16).
- b) Police and Fire Retirement System (D.C. Code, 2001 ed., §§ 5-701 to 5-724).
- c) Judges Retirement System (D.C. Code, 2001 ed., §§ 11-1561 to 11-1572).
- d) Teachers Insurance Annuity Association; or
- e) An employee first employed by the District after September 30, 1987, who has subsequently separated pursuant to the District Retirement Benefit Program (Sections 2603 through 2614 of Employee Benefits Amendment Act Of 1987) after any of the following:
 - i. Reaching fifty-seven (57) years of age and having completed twenty-five (25) years of creditable District service in a law enforcement position;
 - ii. Becoming entitled to retirement benefits under the Social Security Act; or
 - iii. Becoming entitled to disability benefits under the Social Security Act.

C.1.2.2 Co-payment: The amount the participants pay for a specific covered service(s).

C.1.2.3 Coordination of Benefits (COB): An arrangement in health insurance to discourage multiple payments for the same claim under two or more policies. When two or more group health insurance plans cover the insured and dependents, one plan becomes the *primary* plan and the other plan(s) the *secondary* plan(s). For example a plan covering a person as an employee is primary; when a dependent child is covered under two group plans, the parent's plan with the earliest coverage date will pay first unless otherwise authorized in writing by both parents and properly notarized in the state where the children reside or are so court ordered; for children of divorced or separated parents, the plan of the parent with custody shall pay first, if the parent with custody of the child has remarried, that parent's coverage pays first unless otherwise authorized in writing by both parents and properly notarized in the state where the children reside or are so court ordered.

C.1.2.4 Coverage – types of coverage are defined as:

- i. eligible employee (Self only);
- ii. eligible employee and one or more eligible dependents (Family);

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- iii. eligible retiree (Retiree only);
- iv. eligible retiree and one or more eligible dependents (Retiree Family)
- v. eligible TCC (TCC only);
- vi. eligible TCC and one or more eligible dependents (TCC Family).

- C.1.2.5 Deductible:** The amount of covered expenses incurred each calendar year by an insured person before specific benefits are paid.
- C.1.2.6 Eligible Dependent:** An employee's spouse or unmarried dependent children under the age of 22; or if attending an accredited school full-time, under the age of 25.
- C.1.2.7 Eligible Disabled Dependent:** An unmarried dependent child who is incapable of self-support due to physical or mental disability that existed before reaching age 22 while covered under one or both parents' group medical benefit plan(s) and the incapacity can be expected to continue for more than one year.
- C.1.2.8 Eligible Employee:** A District of Columbia government employee who is hired on or after October 1, 1987 and who is eligible for the DC employees' health benefit program.
- C.1.2.9 Employer Contribution:** Funds paid by the District of Columbia government towards each of its sponsored health benefits plan options. The District currently pays 75% and the employee pays 25% of the total premium for each Plan option. The District may pay less than 75% for a given option but never more.
- C.1.2.10 Enrollee:** An employee, retiree, TCC, or other participants enrolled in the health plan, but not including covered dependents.
- C.1.2.11 Health Maintenance Organization (HMO):** A health care system that assumes or shares both the financial risks and the delivery risks associated with providing comprehensive medical services to a voluntarily enrolled population in a particular geographic area. Only visits to professionals within the HMO network are covered by the plan.
- C.1.2.12 No Loss/No Gain:** The situation in which an employer may transfer the group plan from one arrangement to another; despite the change no covered persons, under the previous plan, will lose benefit coverage if they must change benefit plans because a new carrier is awarded the contract. The intention of this concept is that, aside from the actual changes in plan provisions, employees will not gain or lose any earned rights due to circumstances which would not have occurred without an arrangement change. This does not mean participants cannot gain or lose benefits for newly provided benefits; however, participants will not have certain earned rights eliminated.
- C.1.2.13 Participating Provider:** A doctor, hospital, or other covered health care provider in the Preferred Provider network, who is an independent contractor and has an agreement with the District's Contractor to provide health care services to persons insured for Preferred Provider Medical benefits.

- C.1.2.14 Point of Service (POS):** A health plan that allows members to choose to receive services from a participating or non-participating network provider, usually with a financial disincentive for going outside the network.
- C.1.2.15 Preferred Provider Organization (PPO):** A health plan with an established provider network that allows maximum benefit coverage when using its own contracted physicians, hospitals, and other providers. Participants may use providers outside of the set provider network at reduced coverage.
- C.1.2.16 Premium:** Agreed upon fees paid for coverage of medical benefits for a defined benefit period. Premiums can be paid by employers, unions, employees, or shared by both the insured individual and the plan sponsor.
- C.1.2.17 Subcontractor:** Any supplier, distributor, vendor, or firm that furnishes goods or services to, or for a prime contractor or another subcontractor, except for providers of direct medical services or supplies pursuant to the contractor's health benefits plan.
- C.1.2.18 Temporary Continuation of Coverage (TCC):** TCC operates similar to COBRA coverage in the private sector. Those eligible for TCC including the health insurance plan participants listed below based upon a qualifying event:
- i. Employees who separate from District service, voluntarily or involuntarily, and, on the day before separation from service were enrolled in a District of Columbia Employee's Health Benefits Program (DCEHBP) plan, and would not otherwise be eligible for continued coverage, not including the 31-calendar day temporary extension of coverage.
 - ii. Children who have been covered under an employee's, former spouse's or annuitant's enrollment because they had met the requirement of unmarried dependent children of the employee, former spouse, or annuitant, but stop meeting the requirements for being considered unmarried dependent children of the employee, former spouse, or annuitant, and not otherwise be eligible for continued coverage, not including the 31-calendar day temporary extension of coverage. This group includes children who:
 - a) marry before reaching the age of 22;
 - b) lose their coverage because they reach age 22;
 - c) are full-time students and lose their coverage because they reach age 25, or because they cease to be full-time students;
 - d) lose their status as stepchildren or foster children;
 - e) no longer meet the coverage requirements as recognized natural children; or
 - f) are disabled and age 22 and older that either marry, recover from their disability, or become able to support themselves.
 - iii. Former spouses who meet the requirement of having been enrolled as a family member of an employee or annuitant under a health benefits plan at some time

during the preceding 18 months before the marriage ended, but who are not eligible to enroll for health benefits in accordance with spouse equity provisions because they have either: i. remarried before reaching age 55; or ii. are not entitled to a portion of the employee's or annuitant's annuity benefit or a survivor benefit based on the employee's or annuitant's service.

C.2 BACKGROUND

The government of the District of Columbia has administered separate employee benefit programs for those employees first hired on or after October 1, 1987. The program is governed in accordance with all applicable D.C. laws and regulations and, where D.C. laws and regulations are silent, in accordance with federal laws, regulations and procedures (specifically FPM Supplement 890-1) governing the Federal Employee's Health Benefits (FEHB) program. The District of Columbia Employees' Health Benefit (DCEHB) plan currently offers employees hired on or after October 1, 1987 the choice of three HMOs and one PPO health insurance plan.

As of May 2007, there were 9,738 employees enrolled in three (3) HMOs and 3,012 employees enrolled in the PPO, or 12,750 employees, of the approximately 22,000 eligible to receive this benefit, covered in the DCEHB plan.

There is also a Temporary Continuation of Coverage (TCC) program that provides health benefits to approximately 230 former employees and former family members on terms similar to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation of health benefits provisions. (See Attachment J.1.9, District of Columbia Personnel Manual, Chapter 21B, which provides the instructions and definitions for TCC.) There are approximately 281 retirees or survivors participating in the Health Insurance Plan.

Currently, the District's health care benefits are provided on a fully insured prospectively rated basis.

Beginning with the plan year starting January 1, 2008, the District may make the following additional changes to the DCEHB Program:

1. Addition of a POS benefit plan design.
2. Change in plan design for HMOs to have all HMO plan designs be as consistent as possible regarding the benefits, copays, scope of covered services, general limitations and plan exclusions.

Benefits for the current plans are shown in Attachment J.1.2. The current premium rates are as follows:

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Coverage Level	Monthly Premium	
	HMO	PPO
Self	\$270.51 - \$311.75	\$541.19
Family	\$701.73 – \$809.46	\$1,413.96
Self (TCC)	\$275.92 - \$317.98	\$552.01
Family (TCC)	\$715.76 - \$825.65	\$1,442.24

The District is committed to the goal of maximizing the value of its health care expenditures on behalf of its employees and their dependents. There is a strong commitment to managed health care. The District is interested in providing its eligible employees, retirees and their families and TCC participants with the best quality of care at a competitive price that meets all of the District's administrative and benefit requirements.

In addition, the District is looking for insurance provider(s) who will provide effective preventative programs and information that will successfully assist to promote wellness. DCHR's emphasis will focus on education, physical activity, and nutrition.

C.3 REQUIREMENTS

C.3.1 TRANSITION

- C.3.1.1** During the initial start-up period and prior to the start of each subsequent plan year, the Contractor shall conduct all transition activities including, but not limited to, securing claims history from current provider, scheduling meetings with the COTR regarding the transition, coordinating claims for services in process as of the effective date of the benefits plan(s), educating employees of plan design and benefits, issuing identification cards, developing communication materials, and enrolling eligible employees and dependants in the plan(s).
- C.3.1.2** The Contractor shall provide a final transition plan to the Contracting Officer's Technical Representative (COTR) within five (5) days after contract award.
- C.3.1.3** The Contractor shall interface with the District's payroll office to establish an electronic eligibility system to maintain eligibility data. The Contractor shall outline, in its final transition plan, the method to be used to ensure eligibility data is accurately uploaded and prepared for use by the anticipated plan effective date of January 1.
- C.3.1.4** The Contractor shall provide no loss/no gain coverage which shall include active employees, employees on leave without pay (LWOP), sick leave and employees covered by disability compensation
- C.3.1.5** If participants change plan coverage or providers during a plan year, the Contractor shall provide credit for partially and fully satisfied calendar year deductibles and out-

of-pocket maximums satisfied by out-of-network and in-network charges, as applicable under the previous plan design provisions.

C.3.1.6 Due to a change in plan type or provider, the Contractor shall provide for the following services to District enrollees and their dependents upon transition:

1. Pregnant women will be allowed to continue with their current physician at network benefit levels through the birth of their child if they do not wish to switch to an in-network physician.
2. For employees and dependents who are hospitalized, or who suffer with chronic or catastrophic conditions (i.e. any medical condition where total cost of treatment, regardless of payment source, is expected to exceed an amount \$100,000), a 180-calendar day transition period will apply during which time such employees will be identified by the Contractor and have the option to provide, within ninety (90) days, justification for remaining with their current provider or be automatically transitioned to an in-network provider if no justification is received within the 90-day timeframe. During this period, benefits for such persons will be paid at in-network levels although they are receiving treatment from non-network providers or facilities, provided that either the provider/facility is either in the existing network or in the Contractor's network.

This provision would affect participants that are actively receiving services within 30 days of the transition period to the new provider. The provisions of this paragraph shall not apply if the enrollee had the option to stay in the Network under which they were enrolled immediately prior to the engagement of the Contractor.

C.3.1.7 The Contractor shall duplicate the plan design(s) outlined in Attachment J.1.3, Proposed Plan Designs.

C.3.2 ENROLLMENT ASSISTANCE

C.3.2.1 The Contractor shall design and print ID cards, acceptable to the District that includes information about the plan and telephone numbers for utilization of services.

C.3.2.1.1 The Contractor shall submit the design for the ID cards to the COTR, with the final transition plan, for approval prior to issuance. If medical treatment is required prior to the issuance of the identification card, the employee's signed copy of the enrollment form shall serve as identification for plan eligibility purposes.

C.3.2.1.2 The Contractor shall mail identification cards to all employees enrolled in the plan within ten (10) calendar days following receipt of their enrollment notification from the District.

C.3.2.2 The Contractor shall provide booklets and information about the plan in the form of communication materials on an ongoing basis.

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- C.3.2.2.1** The Contractor shall design and print employee booklets which describe the plan benefits, co-pays, and available services (i.e., Summary Plan Descriptions) in such quantities as needed by the District and mail directly to the D.C. Department of Human Resources – Benefits and Retirement Administration, located at 441 4th Street NW – Suite 340N, Washington, DC 20001 or to a HR Advisor at a specified District agency. The Contractor shall mail employee booklets fifteen (15) days prior to an enrollment period. Prior to issuance, the Contractor must submit the booklet to the COTR for approval.
- C.3.2.2.2** The Contractor shall mail other plan-related information to plan participants at the District's request.
- C.3.2.2.3** The Contractor shall provide communication to COTR ninety (90) days prior to any change within the formulary.
- C.3.2.3** The Contractor shall assist DCHR during annual open enrollment season, including providing personnel and printed and video materials necessary to enroll District employees during Open Season. The purpose of the assistance during open season is to have all eligible employees enrolled for a January 1, 2008 initial effective date and each January 1 thereafter.
- C.3.2.4** The Contractor shall participate in annual open enrollment activities, as required by the District, under the general direction of the COTR.
- C.3.2.5** The Contractor shall implement a Wellness Program, at no additional cost, which will provide effective preventive programs and information that will successfully assist to promote employee wellness. The Contractor's program shall include a communication campaign, employee meetings and health fairs that provide an explanation of plan benefits to employees. If requested by the District, the Contractor shall provide professional medical, technical and nutritional personnel to provide blood pressure measurement, visual testing, body-fat testing, healthy cooking and other educational services during health fairs to be conducted annually, at a minimum.
- C.3.2.6** The Contractor shall provide a minimum of four (4) orientation sessions annually with District employee benefits personnel to discuss administrative procedures, program goals and policies to be adhered to under this contract. The Contractor shall instruct District benefits personnel on how to discuss the health care plan and administrative procedures with employees, retirees and annuitants. The Contractor shall assist the District in ongoing employee education about health issues as required.
- C.3.2.7** The Contractor shall, as determined by the District, whenever needed throughout the term of the contract, make up to twenty-five (25) written, oral and video presentations describing the administration of the plan.

C.3.3 PLAN AND CLAIMS ADMINISTRATION

- C.3.3.1** The Contractor shall submit its Administrative Manual which, at minimum, outlines its procedures for administering health plans.
- C.3.3.2** The Contractor shall provide all the services associated with administering the health plan claims, including the Coordination of Benefits, which are incurred during the contract period. This shall include claims that are incurred but not paid as of the end of a plan year or end of the contract term.
- C.3.3.3** The Contractor shall at a minimum replicate the current procedures of the District in administering the plan as set forth in District Personnel Manual and applicable sections of the Federal Personnel Manual. See Attachment J.1.9.
- C.3.3.4** The Contractor shall provide 24-hour direct access for employees to the service center and claims office with local and toll-free phone numbers available for all employee inquiries. The Contractor shall establish minimum office hours from 8:00 a.m. to 5:00 p.m. (Eastern Standard or Daylight Time) Monday through Friday, excluding holidays, during which time employees may speak with a representative.
- C.3.3.5** The Contractor's telephone responses shall be provided by the members of a designated unit who shall be knowledgeable in all aspects of the District's plan and personnel operations. If responses to questions cannot be given immediately, the designated unit member shall contact the employee with a response (or with an estimate of when a response will be provided) on the same day as the initial inquiry.
- C.3.3.6** The Contractor's customer service center shall include representatives fluent in Spanish and other foreign languages predominate to the District Metropolitan Statistical Area. The Contractor shall also provide access to a foreign language service provider, if needed.
- C.3.3.7** The Contractor shall provide separate administrative local and 800 telephone lines for direct communication with District personnel and administrative staff.
- C.3.3.8** The Contractor shall make all its files, records and documentation related to the District health benefits programs available to independent third party auditors during regular business hours named by the District upon ten (10) business days' advance written notice by the District.
- C.3.3.9** The Contractor shall administer thirty-one (31) calendar days of extended benefits following the termination of an enrollment or benefits under an enrollment funded by the District and the employee or person losing coverage. The 31-day extended benefit applies to active enrollments, retired enrollments and TCC enrollments. The 31-day extended coverage period shall commence at the end of the pay period in which active employees separate and at the end of the coverage period for TCC participants and retirees.

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- C.3.3.10** The Contractor shall maintain current, complete and confidential records for each enrollee in accordance with the requirements of HIPAA.
- C.3.3.11** The Contractor shall process all claims and shall provide other services including but not limited to design, review, and printing of claim forms; issue claim forms; make determination of the validity of all claims, pay valid claims and provide mailing services to the District to provide participants with surveys and other information.
- C.3.3.12** The Contractor shall provide Explanation of Benefit (EOB) Statements to enrollees with each claim payment or denial, which includes an explanation of the appeals process within seven (7) days of each claim payment or denial.
- C.3.3.13** The Contractor shall perform yearly verifications of the age and status of student enrollees. The Contractor shall notify the District of any proposed changes to such enrollee coverage thirty (30) days prior to the effective date of the change.
- C.3.3.14** The Contractor shall provide, to enrollees, appropriate correspondence, review and follow-ups in response to all written inquiries, requests for forms and appeals of decisions in accordance with the Contractor's procedures. In addition, the Contractor's procedures shall address the processing of duplicate bills, ineligible claimants and coordination expenses.
- C.3.3.15** The Contractor shall seek third-party reimbursement for covered medical services also covered by primary group health benefit plans and from third parties, other than the insured, held responsible for the cost of covered medical expenses (subrogation) and report savings from such reimbursement quarterly.
- C.3.3.16** The Contractor shall investigate claims for potential fraudulent situations, and report the outcomes and any savings from such investigations quarterly to the COTR.
- C.3.3.17** The Contractor shall provide advice and investigative assistance to the District on disputed claims or potentially fraudulent claims.
- C.3.3.18** The Contractor shall administer benefits, without any pre-existing condition limitations, for existing employees, retirees and dependents and TCCs and for new employees, retirees, and dependents and TCCs that enroll within prescribed guidelines.
- C.3.3.19** The Contractor shall coordinate care and benefits with the existing Employee Assistance Program (EAP) so that participants receive care without interruption.
- C.3.3.20** The Contractor shall price all network provider claims in accordance with the network's contractual provisions with such providers of care.
- C.3.3.21** The Contractor shall keep diagnosis and surgical procedure information using industry standard coding systems and information on patient age, sex, length of stay and complication conditions for use in analysis of hospital utilization based on analytic techniques which use the Diagnostically Related Group (DRG) approach.

- C.3.3.22** The Contractor shall provide benefit plans that shall not mandate a Second Surgical Opinion (SSO), but makes available a SSO to participants who wish to receive a second or third opinion for diagnosis and treatment of an illness. The cost of the second opinion will be reimbursed at 100 percent. The plan will also pay for the cost of a third opinion should the second not agree with the first. The cost of the third opinion will be reimbursed at 100 percent.
- C.3.3.23** The Contractor shall provide health insurance conversion policies for persons leaving the DCEHB after expiration of eligibility for TCC or in lieu of TCC. (Using the standard group conversion, employees electing conversion will be responsible for the full premium with no District contribution.)
- C.3.3.24** The Contractor shall include, as part of the pharmacy benefits, compounded medications containing at least one Federal legend drug; insulin, with or without a prescription, subject to State dispensing laws; needles and syringes, with or without a prescription, subject to State dispensing laws; allergy sera; Rogain, except for male patterned baldness; Retin A, up to the age of 30; Retin A, for patients over the age of 30, for treatment of Acne Vulgaris, Keratosis Follicularis, Ichthyosis Lamellar and Verruca Plana. Covered drugs shall include intrauterine devices (IUDs), Norplant, Depo-Provera, diaphragms, and oral contraceptives dispensed by a retail pharmacy; and oral contraceptives obtained through the mail order program. Covered prescription drugs shall also include those made from blood and blood byproducts for treatment of hemophilia and other blood diseases.
- C.3.3.25** The Contractor shall provide access for enrollees to an available mail order pharmacy.
- C.3.3.26** The Contractor shall provide and maintain a formulary, a list of prescription drugs that a health plan has approved for use by doctors that may receive preferential treatment via lower copays. If a change to the formulary occurs during a plan year, the Contractor shall provide notification ninety (90) days prior to the effective date of such change.
- C.3.3.27** The Contractor shall include the formulary in all Plan Summary documents.

C.3.4 REPORTING

- C.3.4.1** The Contractor shall reconcile its eligibility records with all the District eligibility and payment records. This reconciliation shall be conducted monthly and reported to the COTR within thirty (30) days of the end of each month. The Contractor's reconciliation shall require certification of enrollees by name, social security number and enrollment code. The Contractor shall submit reconciliations electronically in an agreed upon format to the COTR.
- C.3.4.2** The Contractor shall report monthly and year-to-date customer service inquiry statistics including number of calls by major category, inquiries resolved in one call, wait times, abandonment rates, call duration, and other statistics as specified by the District to the COTR on a quarterly basis.

- C.3.4.3** The Contractor shall provide, to the COTR on a quarterly basis, an Income and Expenditures report by plan showing amounts deposited by the District (including the date such electronic payments were received) and claims paid for services incurred by plan members, enrollment, and separately identified catastrophic claims in an electronic format. The claim level for the catastrophic claim report will be determined by the COTR.
- C.3.4.4** The Contractor shall cooperate with and act in good faith in working with the consulting actuary and must be prepared to respond to the actuary's requests promptly. In that regard, or for other purposes, from time to time District may, on an ad hoc basis, request that the Contractor prepare customized reports or provide the District with individual claims data on a timely basis at no additional cost to the District. The Contractor's reports shall be submitted to the COTR in a mutually agreed upon timeline.
- C.3.4.5** The Contractor shall report, to the COTR on a quarterly basis, monthly and year-to-date claims processing statistics including number of claims received, pended, denied, paid; claims received and pended inventories (number on hand at each week's end); and turnaround/aging statistics to be specified by the District.
- C.3.4.6** The Contractor shall report, to the COTR on a quarterly basis, monthly and year-to-date claims payment accuracy statistics from its internal auditing process including number and amount of overpayments, underpayments, mis-coded claims, and other statistics as specified by the COTR.
- C.3.4.7** The Contractor shall provide, to the COTR, electronic quarterly reports by plan for the following groups:
- a.** In Network Plan claims and utilization;
 - b.** Out-of-Network claims and utilization;
 - c.** Active enrolled D.C. Employees and Dependents by Rating Tier (self only and family);
 - d.** Temporary Continuation of Coverage enrollments;
 - e.** Retired enrolled D.C. Employees and Dependents by Rating Tier (self only and family); and
 - f.** Retired enrolled D.C. Employees and Dependents by Rating Tier (self only and family).
- C.3.4.8** The Contractor shall perform an annual account reconciliation of monthly claims, administration, and other expenditures and prepare a detailed report for the COTR within three (3) months following the close of the plan year.
- C.3.4.9** The Contractor shall provide on a quarterly basis a de-identified list of all claims greater than \$10,000.

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- C.3.4.10** The Contractor shall submit semi-annually, a Hospital Utilization Report showing the number of employees using each hospital by plan, the lengths of stay and the net amounts paid, including coordination of benefits and other third party liability recoveries to the COTR.
- C.3.4.11** The Contractor shall submit on a quarterly basis to the COTR reports of claims incurred by plan by month and year, and by therapeutic class, showing number of claims, number of prescriptions, number of days supply, and net amount paid.
- C.3.4.12** The Contractor shall provide, to the COTR, quarterly reports for each plan for the following:
- a.** Retail Network claims pre and post discounts, dispensing fees and amount paid by generic, formulary and non-formulary classifications;
 - b.** Mail Order claims pre and post discounts, dispensing fees and amount paid by generic, formulary and non-formulary classifications;
 - c.** Brand utilization when generics are available;
 - d.** Out-of-Network claims pre and post discounts, dispensing fees and amount paid by generic, formulary and non-formulary classifications;
 - e.** Active enrolled D.C. Employees;
 - f.** Temporary Continuation of Coverage enrollments; and
 - g.** Retired enrolled D.C. Employees, split by pre- and post-Medicare
- C.3.4.13** The Contractor shall keep in its individual claim records, the following information at a minimum:
- a.** Date of service
 - b.** ID Number
 - c.** National Drug Code (11 digit NDC)
 - d.** Drug Type Indicator (single source, multi-source, generic)
 - e.** Maintenance Drug Indicator
 - f.** Formulary Drug Indicator
 - g.** National Council for Prescription Drug Programs (NCPDP) Provider Identification Number (formerly known as NABP Number)
 - h.** Days Supply
 - i.** Quantity
 - j.** Net Ingredient Cost
 - k.** Dispensing Fee
 - l.** Member Copayment
 - m.** Amount Applied to Deductible
 - n.** Plan Payment
 - o.** Average Wholesale Price
 - p.** Date Pharmacy Paid
- C.3.4.14** The Contractor shall furnish on-line access to reports to the District.
- C.3.4.15** The Contractor shall provide benchmark data on plan costs and utilization with suggestions for plan improvement and cost efficiency, on a quarterly basis, to the COTR.

C.3.5 QUALITY ASSURANCE

C.3.5.1 The Contractor shall submit a comprehensive Quality Management Program that includes, at a minimum, grievance procedures, provider credentialing and termination policies, incentive plan for service providers, monitoring procedures for care management, and a dispute resolution strategy.

C.3.5.2 The Contractor shall conduct annual surveys of District enrollees during the last month of the plan year to determine their satisfaction with the program using a District-developed survey. The Contractor shall return the completed surveys to the Contracting Officer's Technical Representative within three (3) months following the close of the plan year.

C.3.5.3 The Contractor shall provide performance guarantees. The Contractor's performance guarantees shall include liquidated damages to be paid by the Contractor in the event of delays or the failure of performance by the Contractor. The Contractor shall submit payment to the District for such liquidated damages in accordance with the approved surveillance plan.

C.3.6 CARE MANAGEMENT

C.3.6.1 The Contractor shall provide Care Management services to help ensure that high quality medical care is being provided in a cost efficient manner. Services shall be provided in the form of systems and techniques used to control the use of health care services. The Contractor shall perform a review of medical necessity, incentives to use certain providers, and case management. The Contractor shall develop a system of health payment and delivery of service arrangement wherein the plan shall attempt to control or coordinate use of health services by its enrolled employees in order to contain health expenditures, improve quality or both.

C.3.6.2 The Contractor shall monitor hospital admissions and discharges as well as identify potential catastrophic cases. The Contractor shall then work with the patient, the patient's family, the health care community and the local resources to see that quality care is provided in the most cost efficient setting, which may include centers of excellence. This may include arranging for services not normally within the scope of the plan in lieu of covered services as defined by the District.

C.3.6.3 The Contractor shall establish an employee advice line where District employees may call for advice and guidance on benefits available under the District's plan and alternate treatment settings where covered services can be rendered. Advice shall be provided by members of the designated unit. The Contractor's advice line shall be in accordance with C.3.3.5.

C.3.6.4 The Contractor shall provide a drug utilization review program to help ensure that prescribed medications are appropriate, medically necessary, and are not likely to result in adverse medical outcomes.

C.3.7 PROVIDER QUALIFICATION AND ACCESS

- C.3.7.1** The Contractor shall maintain a provider network that provides health care coverage for the District's eligible active employees, retirees and TCC participants. For participants living in the Washington metropolitan area, the provider network shall maintain, at a minimum, two (2) network physicians within eight (8) miles of each enrollee's residence.
- C.3.7.2** The Contractor shall maintain an applicable network of retail pharmacies that provides coverage for the District's eligible active employees, retirees and TCC participants. The Contractor shall also provide pharmacy access for retirees, students and TCC participants residing outside the service area.
- C.3.7.3** The Contractor shall expand, as the Contractor deems necessary or at the COTR's request, during the contract term, its network with practices accepting new patients to meet the District's requirements or to add providers in network locations where coverage gaps exist. The Contractor shall expand its network within thirty (30) days of receipt of written request from the COTR and provide written notification, to the COTR and plan participants regarding the addition of providers.
- C.3.7.4** The Contractor shall provide out-of-area coverage to enrollees and dependents, while traveling outside of the Washington Metropolitan network area.
- C.3.7.5** The Contractor shall provide, prior to the initial plan year and throughout the term of the contract, on-line access to up-to-date network provider listings and locations to assist participants with provider selection.
- C.3.7.6** The Contractor shall notify the COTR at least ninety (90) days in advance, or as soon as practical of any significant changes (i.e. effect more than twenty-five (25) participants) to the provider network or to the reimbursement levels paid to providers. Such notice shall include the estimated impact on the District and its participants.
- C.3.7.7** The Contractor shall include in its Quality Management Program review of the following:
- a.** Adherence to treatment guidelines and protocols;
 - b.** Ongoing maintenance and evaluation of the quality and appropriateness of care;
 - c.** Utilization management;
 - d.** Process for reviewing and approving credentials of patient care professionals;
 - e.** Clinical aspects of risk management;
 - f.** Infection control; and
 - g.** Facility quality (i.e., location, cleanliness, parking).
- C.3.7.8** During the term of the contract, the Contractor shall provide a minimum rebate guarantee using a fixed amount per paid claim.

C.3.7.9 The Contractor shall manage costs through the Contractor's network discounts, utilization controls and plan management. The Contractor shall reflect any cost savings in the premiums charged to the District and coinsurance paid by plan participants. In addition, the Contractor shall maintain information showing individual and aggregate discounts off the usual and customary charges and provide it to the District as requested.

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SECTION D: PACKAGING AND MARKING

NOT APPLICABLE

SECTION E: INSPECTION AND ACCEPTANCE

The inspection and acceptance requirements for the resultant contract shall be governed by clause number six (6), Inspection of Services, of the Government of the District of Columbia's Standard Contract Provisions for use with Supplies and Services Contracts, dated March 2007.

SECTION F: DELIVERIES OR PERFORMANCE

F.1 TERM OF CONTRACT

The Contractor may be granted a start up period for transition services prior to the commencement date of the actual contract. During the start-up period, the Contractor shall prepare drafts of all communication materials, administration manuals and provide the necessary interface between the District's electronic eligibility and payment systems. The initial plan year shall be from January 1, 2008 through December 31, 2008. Each subsequent plan year will begin on January 1 of that year.

F.2 OPTION TO EXTEND THE TERM OF THE CONTRACT

F.2.1 The District may extend the term of this contract for a period of four (4) –one year option periods, or successive fractions thereof, by written notice to the Contractor before the expiration of the contract; provided that the District will give the Contractor a preliminary written notice of its intent to extend at least thirty (30) days before the contract expires. The preliminary notice does not commit the District to an extension. The exercise of this option is subject to the availability of funds at the time of the exercise of this option. The Contractor may waive the thirty (30) day preliminary notice requirement by providing a written waiver to the Contracting Officer prior to expiration of the contract.

F.2.2 If the District exercises this option, the extended contract shall be considered to include this option provision.

F.2.3 The Contractor's fees to be charged during the option period shall be as specified in the contract. The Contractor shall submit any changes to fees or rates, such as those based on a formula, to the District one hundred twenty (120) days prior to the effective date of the change.

The Contractor shall provide a retrospective rating adjustment where the District will receive a refund or credit for favorable experience. The District, however, will be under no obligation to reimburse the Contractor for unfavorable experience.

F.2.4 The total duration of this contract, including the exercise of all options under this clause, shall not exceed five (5) years beyond the transition period.

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F.3 DELIVERABLES

SOW Section	Deliverable	Quantity	Format/Method of Delivery	Due Date
	PLAN DOCUMENTS			
C.3.1.2	Final Transition Plan	1	Electronic or Hard Copy	5 days after contract award
C.3.2.1.2	ID Cards	As needed	Mail	10 calendar days following receipt of enrollment
C.3.2.2.1	Employee Booklets	As needed	Mail to DCHR	15 days prior to enrollment period
C.3.2.2.2	Other plan related information	As needed	Mail to participants	As needed throughout the contract term
C.3.2.2.3 and C.3.3.2.6	Notification of Change in Formulary	As needed	Electronic or Hard Copy	90 days prior to any change in the formulary
C.3.2.6	Orientation Session	4	Sessions	Annually
C.3.2.7	Written, Oral and Video Presentations	Up to 25	As determined by COTR and Contractor	Throughout contract term
C.3.3.8	Documentation related to District Programs for third-party auditor	As needed	Hard Copy	Within 10 days of receipt of notice from COTR
C.3.3.12	EOB Statements to Employees	As needed	Hard Copy	Within 7 days of claim payment/denial
C.3.3.13	Yearly Verification of Student Enrollees	As needed	Hard Copy/Electronic Format	30 days prior to any proposed changes
C3.3.14	Responses to inquiries, request for forms and appeals of decisions	As needed	In accordance with Contractor's procedures	Throughout contract term
C.3.5.2	Annual survey of District enrollees	As needed	Hard Copy	Within 3 month of close of plan year
C.3.7.3	Written notification of expansion of Provider Network	As needed	Electronic or Hard Copy	Within 30 days of receipt of District's request
C.3.7.6	Notification of significant changes to provider network or reimbursement levels	As needed	Hard Copy or Electronic Format	90 days prior to change or as soon as practical
C.3.7.10	Individual and aggregate discounts of U&C charges	As needed	Hard Copy or Electronic Format	As requested, throughout contract term
G.3.3	Verification of eligibility for services provided to employees not shown on bi-weekly pay listing	As needed	Hard Copy or Electronic Format	Within 72 hours of service being provided
G.3.4	Reimbursement of overpayment	As needed	Check	30 days of notification of payment
	REPORTS			
C.3.3.15	Quarterly report of savings from third party reimbursements	As needed	Hard Copy or Electronic Format	Quarterly

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SOW Section	Deliverable	Quantity	Format/Method of Delivery	Due Date
C.3.4.1	Monthly reconciliation	1	Hard Copy or Electronic Format	Within 30 days of the end of each month
C.3.4.8	Annual account reconciliation	1	Hard Copy or Electronic Format	Within 3 months following the close of each plan year
C.3.4.2, C.3.4.5 and C.3.4.6	Monthly and YTD customer service inquiry statistics, claim processing statistics and payment accuracy statistics	1	Hard Copy or Electronic Format	Quarterly
C.3.4.3	Income and Expenditure report	1	Hard Copy or Electronic Format	Quarterly
C.3.4.7	Utilization reports	1	Hard Copy or Electronic Format	Quarterly
C.3.4.9	De-identified claims < \$10K	1	Hard Copy or Electronic Format	Quarterly
C.3.4.10	Hospital Utilization Report	1	Hard Copy or Electronic Format	Semi-annually
C.3.4.11	Claims Incurred	1	Hard Copy or Electronic Format	Quarterly
C.3.4.12	General Reports	1	Hard Copy or Electronic Format	Quarterly
C.3.4.15	Benchmarking Data	1	Hard Copy or Electronic Format	Quarterly

SECTION G: CONTRACT ADMINISTRATION DATA

G.1 INVOICE PAYMENT

G.1.1 The Contractor shall not invoice the District. The District's eligibility and premium remittance shall be on a self-accounting basis. The Contractor shall accept the electronic payments made by the District at the end of each pay period as payment in full, except as provided for in G.3.3 below.

G.2 FIRST SOURCE AGREEMENT REQUEST FOR FINAL PAYMENT

G.2.1 For contracts subject to the 51% District Residents New Hires Requirements and First Source Employment Agreement requirements, final request for payment must be accompanied by the report or a waiver of compliance discussed in section H.5.5.

G.2.2 No final payment shall be made to the Contractor until the CFO has received the Contracting Officer's final determination or approval of waiver of the Contractor's compliance with 51% District Residents New Hires Requirements and First Source Employment Agreement requirements.

G.3 PAYMENT

G.3.1 The District shall provide the Contractor with electronic eligibility from the payroll system for the agencies under the authority of the Mayor. For such agencies under the UPPS payroll system, payment shall be electronic. For such agencies under the CAPPs payroll system, payment shall be by check until such time as the CAPPs system is converted back to the UPPS system. The Contractor shall not invoice the District but shall accept the District's electronic eligibility system and electronic remittance as payment in full. The banks levy a per transaction charge for utilization of the electronic eligibility information and payment. The Contractor shall be responsible for payment of such charges and should build this cost into the administrative component of their premium rate. The District is in the process of implementation of the People Soft Human Resource System. This may impact the transmittal of eligibility and payment data.

G.3.2 Agencies that are independent and have their own payroll system will transmit their eligibility separately. Agencies or organizations that are presently remitting their premium separately are D. C. Housing Authority and D.C. Retirement Board (Police, Fire and Teacher Retirees). The Contractor shall establish method of eligibility, update method of payment and frequency of payment with each independent agency.

G.3.3 The Contractor shall provide services only to employees shown on the bi-weekly pay listings. If there was no health premium payment made for an employee, the Contractor shall only provide service for such employee upon approval by the COTR. If the COTR is not available, then the Contractor shall provide coverage for a period not to exceed seventy-two (72) hours as long as the employee presents either their plan ID card or enrollment form. If upon verification by the COTR that the employee

is covered, the Contractor will be paid any back premium. If the employee is not covered, the Contractor will only be paid any back premium if it did not see verification within the 72-hour period.

- G.3.4** The District will receive credits for overpayment as determined by the COTR for an unlimited retroactive period. The Contractor shall submit a payment check within thirty (30) days of the notification of overpayment.
- G.3.5** The Contractor **shall not** use premium payments by a covered employee to the Contractor/Subcontractor to offset any obligation or satisfy any debt which the Contractor/ Subcontractor deems owed to them by the Government of the District of Columbia. Any such disputes in amounts owed (service fees, contract administration fees, etc.), once resolved, shall only be satisfied by payments received from the employer, the Government of the District of Columbia.

G.4 ASSIGNMENT OF CONTRACT PAYMENTS

- G.4.1** In accordance with 27 DCMR 3250, the Contractor may assign funds due or to become due as a result of the performance of this contract to a bank, trust company, or other financing institution.
- G.4.2** Any assignment shall cover all unpaid amounts payable under this contract, and shall not be made to more than one party.
- G.4.3** Notwithstanding an assignment of contract payments, the Contractor, not the assignee, is required to prepare invoices. Where such an assignment has been made, the original copy of the invoice must refer to the assignment and must show that payment of the invoice is to be made directly to the assignee as follows:

Pursuant to the instrument of assignment dated _____,
make payment of this invoice to _____
(name and address of assignee).

G.5 THE QUICK PAYMENT CLAUSE

G.5.1 Interest Penalties to Contractors

- G.5.1.1** The District will pay interest penalties on amounts due to the Contractor under the Quick Payment Act, D.C. Official Code §2-221.01 et seq., for the period beginning on the day after the required payment date and ending on the date on which payment of the amount is made. Interest shall be calculated at the rate of 1% per month. No interest penalty shall be paid if payment for the completed delivery of the item of property or service is made on or before:
- a) the 3rd day after the required payment date for meat or a meat product;
 - b) the 5th day after the required payment date for an agricultural commodity; or
 - c) the 15th day after the required payment date for any other item.

G.5.1.2 Any amount of an interest penalty which remains unpaid at the end of any 30-day period shall be added to the principal amount of the debt and thereafter interest penalties shall accrue on the added amount.

G.5.2 Payments to Subcontractors

G.5.2.1 The Contractor must take one of the following actions within 7 days of receipt of any amount paid to the Contractor by the District for work performed by any subcontractor under a contract:

- a) Pay the subcontractor for the proportionate share of the total payment received from the District that is attributable to the subcontractor for work performed under the contract; or
- b) Notify the District and the subcontractor, in writing, of the Contractor's intention to withhold all or part of the subcontractor's payment and state the reason for the nonpayment.

G.5.2.2 The Contractor must pay any lower-tier subcontractor or supplier interest penalties on amounts due to the subcontractor or supplier beginning on the day after the payment is due and ending on the date on which the payment is made. Interest shall be calculated at the rate of 1% per month. No interest penalty shall be paid on the following if payment for the completed delivery of the item of property or service is made on or before:

- a) the 3rd day after the required payment date for meat or a meat product;
- b) the 5th day after the required payment date for an agricultural commodity; or
- c) the 15th day after the required payment date for any other item.

G.5.2.3 Any amount of an interest penalty which remains unpaid by the Contractor at the end of any 30-day period shall be added to the principal amount of the debt to the subcontractor and thereafter interest penalties shall accrue on the added amount.

G.5.2.4 A dispute between the Contractor and subcontractor relating to the amounts or entitlement of a subcontractor to a payment or a late payment interest penalty under the Quick Payment Act does not constitute a dispute to which the District of Columbia is a party. The District of Columbia may not be interpleaded in any judicial or administrative proceeding involving such a dispute.

G.6 CONTRACTING OFFICER (CO)

Contracts will be entered into and signed on behalf of the District only by contracting officers. The name, address and telephone number of the Contracting Officer is:

Name of Contracting Officer:	Gena Johnson
Address:	Office of Contracting and Procurement 441 4th Street NW, Suite 700S Washington, DC 20001
Telephone:	202-727-0252

G.7 AUTHORIZED CHANGES BY THE CONTRACTING OFFICER

- G.7.1** The Contracting Officer is the only person authorized to approve changes in any of the requirements of this contract.
- G.7.2** The Contractor shall not comply with any order, directive or request that changes or modifies the requirements of this contract, unless issued in writing and signed by the Contracting Officer.
- G.7.3** In the event the Contractor effects any change at the instruction or request of any person other than the Contracting Officer, the change will be considered to have been made without authority and no adjustment will be made in the contract price to cover any cost increase incurred as a result thereof.

G.8 CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE (COTR)

- G.8.1** The COTR is responsible for general administration of the contract and advising the Contracting Officer as to the Contractor's compliance or noncompliance with the contract. In addition, the COTR is responsible for the day-to-day monitoring and supervision of the contract, of ensuring that the work conforms to the requirements of this contract and such other responsibilities and authorities as may be specified in the contract. The COTR for this contract is:

Name: Adrienne Moore
Title: Associate Director for Compensation,
Classification & Benefits Administration
Agency: Department of Human Resources
Address: 441 4th Street, NW, Suite 340N
Washington, DC 20001
Telephone: (202) 442-9666

- G.8.2** The COTR does not have authority to make any changes in the specifications or scope of work or terms and conditions of the contract.
- G.8.3** The Contractor may be held fully responsible for any changes not authorized in advance, in writing, by the Contracting Officer; may be denied compensation or other relief for any additional work performed that is not so authorized; and may also be required, at no additional cost to the District, to take all corrective action necessitated by reason of the unauthorized changes.

SECTION H: SPECIAL CONTRACT REQUIREMENTS

H.1 HIRING OF DISTRICT RESIDENTS AS APPRENTICES AND TRAINEES

H.1.1 For all new employment resulting from this contract or subcontracts hereto, as defined in Mayor's Order 83-265 and implementing instructions, the Contractor shall use its best efforts to comply with the following basic goal and objectives for utilization of bona fide residents of the District of Columbia in each project's labor force:

H.1.1.1 at least fifty-one (51) percent of apprentices and trainees employed shall be residents of the District of Columbia registered in programs approved by the District of Columbia Apprenticeship Council.

H.1.2 The Contractor shall negotiate an Employment Agreement with the DOES for jobs created as a result of this contract. The DOES shall be the Contractor's first source of referral for qualified applicants, trainees, and other workers in the implementation of employment goals contained in this clause.

H.2 DEPARTMENT OF LABOR WAGE DETERMINATIONS

The Contractor shall be bound by the Wage Determination No. 2005-2103, Revision 4, dated 7/5/07, issued by the U.S. Department of Labor in accordance with the Service Contract Act (41 U.S.C. 351 *et seq.*) and incorporated herein as Section J.1.1 of this solicitation. The Contractor shall be bound by the wage rates for the term of the contract. If an option is exercised, the Contractor shall be bound by the applicable wage rate at the time of the option. If the option is exercised and the Contracting Officer obtains a revised wage determination, the revised wage determination is applicable for the option periods and the Contractor may be entitled to an equitable adjustment.

H.3 PUBLICITY

The Contractor shall at all times obtain the prior written approval from the Contracting Officer before it, any of its officers, agents, employees or subcontractors, either during or after expiration or termination of the contract, make any statement, or issue any material, for publication through any medium of communication, bearing on the work performed or data collected under this contract.

H.4 FREEDOM OF INFORMATION ACT

The District of Columbia Freedom of Information Act, at D.C. Official Code § 2-532 (a-3), requires the District to make available for inspection and copying any record produced or collected pursuant to a District contract with a private contractor to perform a public function, to the same extent as if the record were maintained by the agency on whose behalf the contract is made. If the Contractor receives a request for such information, the Contractor shall immediately send the request to the COTR designated in subsection G.9 who will provide the request to the FOIA Officer for the agency with programmatic responsibility

in accordance with the D.C. Freedom of Information Act. If the agency with programmatic responsibility receives a request for a record maintained by the Contractor pursuant to the contract, the COTR will forward a copy to the Contractor. In either event, the Contractor is required by law to provide all responsive records to the COTR within the timeframe designated by the COTR. The FOIA Officer for the agency with programmatic responsibility will determine whether and under what conditions the records may be released. The District will reimburse the Contractor for the costs of searching and copying the records in accordance with D.C. Official Code § 2-532 and Chapter 4 of Title 1 of the *D.C. Municipal Regulations*.

H.5 51% DISTRICT RESIDENTS NEW HIRES REQUIREMENTS AND FIRST SOURCE EMPLOYMENT AGREEMENT

H.5.1 The Contractor shall comply with the First Source Employment Agreement Act of 1984, as amended, D.C. Official Code, sec. 2-219.01 et seq. (“First Source Act”).

H.5.2 The Contractor shall enter into and maintain, during the term of the contract, a First Source Employment Agreement, (Section J.2.4) in which the Contractor shall agree that:

1. The first source for finding employees to fill all jobs created in order to perform this contract shall be the Department of Employment Services (“DOES”); and
2. The first source for finding employees to fill any vacancy occurring in all jobs covered by the First Source Employment Agreement shall be the First Source Register.

H.5.3 The Contractor shall submit to DOES, no later than the 10th each month following execution of the contract, a First Source Agreement Contract Compliance Report (“contract compliance report”), verifying its compliance with the First Source Agreement for the preceding month. The contract compliance report for the contract shall include the:

1. Number of employees needed;
2. Number of current employees transferred;
3. Number of new job openings created;
4. Number of job openings listed with DOES;
5. Total number of all District residents hired for the reporting period and the cumulative total number of District residents hired; and
6. Total number of all employees hired for the reporting period and the cumulative total number of employees hired, including:
 - a) Name;
 - b) Social Security number;
 - c) Job title;
 - d) Hire date;
 - e) Residence; and
 - f) Referral source for all new hires.

H.5.4 If the contract amount is equal to or greater than \$100,000, the Contractor agrees that 51% of the new employees hired for the contract shall be District residents.

H.5.5 With the submission of the Contractor's final request for payment from the District, the Contractor shall:

1. Document in a report to the Contracting Officer its compliance with the section H.5.4 of this clause; or
2. Submit a request to the Contracting Officer for a waiver of compliance with section H.5.4 and include the following documentation:
 - a) Material supporting a good faith effort to comply;
 - b) Referrals provided by DOES and other referral sources;
 - c) Advertisement of job openings listed with DOES and other referral sources; and
 - d) Any documentation supporting the waiver request pursuant to section H.5.6.

H.5.6 The Contracting Officer may waive the provisions of section H.5.4 if the Contracting Officer finds that:

1. A good faith effort to comply is demonstrated by the Contractor;
2. The Contractor is located outside the Washington Standard Metropolitan Statistical Area and none of the contract work is performed inside the Washington Standard Metropolitan Statistical Area which includes the District of Columbia; the Virginia Cities of Alexandria, Falls Church, Manassas, Manassas Park, Fairfax, and Fredericksburg, the Virginia Counties of Fairfax, Arlington, Prince William, Loudoun, Stafford, Clarke, Warren, Fauquier, Culpepper, Spotsylvania, and King George; the Maryland Counties of Montgomery, Prince Georges, Charles, Frederick, and Calvert; and the West Virginia Counties of Berkeley and Jefferson.
3. The Contractor enters into a special workforce development training or placement arrangement with DOES; or
4. DOES certifies that there are insufficient numbers of District residents in the labor market possessing the skills required by the positions created as a result of the contract.

H.5.7 Upon receipt of the contractor's final payment request and related documentation pursuant to sections H.5.5 and H.5.6, the Contracting Officer shall determine whether the Contractor is in compliance with section H.5.4 or whether a waiver of compliance pursuant to section H.5.6 is justified. If the Contracting Officer determines that the Contractor is in compliance, or that a waiver of compliance is justified, the Contracting Officer shall, within two business days of making the determination forward a copy of the determination to the Agency Chief Financial Officer and the COTR.

H.5.8 Willful breach of the First Source Employment Agreement, or failure to submit the report pursuant to section H.5.5, or deliberate submission of falsified data, may be enforced by the Contracting Officer through imposition of penalties, including monetary fines of 5% of the total amount of the direct and indirect labor costs of the contract. The Contractor shall make payment to DOES. The Contractor may appeal to the D.C. Contract Appeals Board as provided in the contract any decision of the Contracting Officer pursuant to this section H.5.8.

H.5.9 The provisions of sections H.5.4 through H.5.8 do not apply to nonprofit organizations.

H.6 WAY TO WORK AMENDMENT ACT OF 2006

H.6.1 Except as described in H.6.8 below, the Contractor shall comply with Title I of the Way to Work Amendment Act of 2006, effective June 9, 2006 (D.C. Law 16-118, D.C. Official Code §2-220.01 *et seq.*) (“Living Wage Act of 2006”), for contracts for services in the amount of \$100,000 or more in a 12-month period.

H.6.2 The Contractor shall pay its employees and subcontractors who perform services under the contract no less than the current living wage published on the OCP website at www.ocp.dc.gov.

H.6.3 The Contractor shall include in any subcontract for \$15,000 or more a provision requiring the subcontractor to pay its employees who perform services under the contract no less than the current living wage rate.

H.6.4 The Department of Employment Services may adjust the living wage annually and the OCP will publish the current living wage rate on its website at www.ocp.dc.gov.

H.6.5 The Contractor shall provide a copy of the Fact Sheet attached as J.1.15 to each employee and subcontractor who performs services under the contract. The Contractor shall also post the Notice attached as J.1.14 in a conspicuous place in its place of business. The Contractor shall include in any subcontract for \$15,000 or more a provision requiring the subcontractor to post the Notice in a conspicuous place in its place of business.

H.6.6 The Contractor shall maintain its payroll records under the contract in the regular course of business for a period of at least three (3) years from the payroll date, and shall include this requirement in its subcontracts for \$15,000 or more under the contract.

H.6.7 The payment of wages required under the Living Wage Act of 2006 shall be consistent with and subject to the provisions of D.C. Official Code §32-1301 *et seq.*

H.6.8 The requirements of the Living Wage Act of 2006 do not apply to:

- (1) Contracts or other agreements that are subject to higher wage level determinations required by federal law;
- (2) Existing and future collective bargaining agreements, provided, that the future collective bargaining agreement results in the employee being paid no less than the established living wage;
- (3) Contracts for electricity, telephone, water, sewer or other services provided by a regulated utility;
- (4) Contracts for services needed immediately to prevent or respond to a disaster or eminent threat to public health or safety declared by the Mayor;
- (5) Contracts or other agreements that provide trainees with additional services including, but not limited to, case management and job readiness services; provided that the trainees do not replace employees subject to the Living Wage Act of 2006;
- (6) An employee under 22 years of age employed during a school vacation period, or enrolled as a full-time student, as defined by the respective institution, who is in high school

or at an accredited institution of higher education and who works less than 25 hours per week; provided that he or she does not replace employees subject to the Living Wage Act of 2006;

(7) Tenants or retail establishments that occupy property constructed or improved by receipt of government assistance from the District of Columbia; provided, that the tenant or retail establishment did not receive direct government assistance from the District;

(8) Employees of nonprofit organizations that employ not more than 50 individuals and qualify for taxation exemption pursuant to section 501(c)(3) of the Internal Revenue Code of 1954, approved August 16, 1954 (68A Stat. 163; 26 U.S.C. § 501(c)(3));

(9) Medicaid provider agreements for direct care services to Medicaid recipients, provided, that the direct care service is not provided through a home care agency, a community residence facility, or a group home for mentally retarded persons as those terms are defined in section 2 of the Health-Care and Community Residence Facility, Hospice, and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-501); and

(10) Contracts or other agreements between managed care organizations and the Health Care Safety Net Administration or the Medicaid Assistance Administration to provide health services.

H.6.9 The Mayor may exempt a contractor from the requirements of the Living Wage Act of 2006, subject to the approval of Council, in accordance with the provisions of Section 109 of the Living Wage Act of 2006.

H.7 PROTECTION OF PROPERTY:

The Contractor shall be responsible for any damage to the building, interior, or their approaches in delivering equipment covered by this contract.

H.8 AMERICANS WITH DISABILITIES ACT OF 1990 (ADA)

During the performance of the contract, the Contractor and any of its subcontractors shall comply with the ADA. The ADA makes it unlawful to discriminate in employment against a qualified individual with a disability. See 42 U.S.C. 12101 et seq.

H.9 SECTION 504 OF THE REHABILITATION ACT OF 1973, as amended.

During the performance of the contract, the Contractor and any of its subcontractors shall comply with Section 504 of the Rehabilitation Act of 1973, as amended. This Act prohibits discrimination against disabled people in federally funded program and activities. See 29 U.S.C. 794 et seq.

H.10 DISTRICT RESPONSIBILITIES

The COTR will approve the Contractor's plan for enrollment and delivery of services to eligible participants including plan documents, booklets, I.D. cards, and any changes in benefits. The D.C. Office of Pay and Retirement Services will provide biweekly payments based upon eligibility data, including additions and deletions based on payroll status of the employees. The biweekly payroll data will form the basis for potential payments to the

Contractor for services actually delivered to eligible Plan participants, excluding co-payment. The Department of Human Resources will assist the Contractor in the dissemination of information developed by the Contractor to inform employees of the Plan's availability, benefits offered, eligibility, and how to participate.

H.11 DIVERSION, REASSIGNMENT AND REPLACEMENT OF KEY PERSONNEL

The key personnel specified in the contract are considered to be essential to the work being performed hereunder. Prior to diverting any of the specified key personnel for any reason, the Contractor shall notify the Contracting Officer at least thirty calendar days in advance and shall submit justification (including proposed substitutions, in sufficient detail to permit evaluation of the impact upon the contract. The Contractor shall obtain written approval of the Contracting Officer for any proposed substitution of key personnel.

For this contract, key personnel shall include the Account Manager and the Claims Manager.

H.12 LICENSES & PERMITS

The Contractor shall, without additional expense to the District, be responsible for obtaining all licenses and permits which are necessary to fulfill the requirements of the Scope of Work.

H.13 SUBCONTRACTORS

For the purposes of this contract, providers of direct dental services or supplies to plan participants pursuant to the Contractor's dental benefits plan are not considered subcontractors. The District encourages the use of certified Local, Small, Disadvantaged Businesses (LSDBEs) to the maximum extent practicable.

H.14 DEBARRED PROVIDER RESTRICTION

Contractor certifies, by signing this contract, that the Contractor, its principals, subcontractors, and all providers or suppliers rendering dental services or supplies pursuant to this contract are not presently excluded from participation in Medicare and State health care programs by the United States Department of Health and Human Services. Furthermore, the Contractor certifies that no services or supplies rendered during the course of this contract shall be provided or supplied by any individual or entity that has been excluded in said manner.

H.15 AUDITS, RECORDS, AND RECORD RETENTION

H.15.1 Contractor shall perform reconciliation of eligibility data provided by the D.C. Office of Pay and Retirement Services, as stated herein in Section C.3.4.1 of this solicitation, within thirty-one (31) days of the previous benefit month. If, during the reconciliation process, the Contractor discovers discrepancy in the data provided by the District and its own, the Contractor is responsible for contacting the COTR within five (5) days of said discovery. Upon notification, the District has five (5) days to respond to Contractor's inquiry. The

entire process for resolution of such discrepancies must be completed within the thirty-one (31) day time period allotted for reconciliation.

H.15.2 At any time or times before final payment and three (3) years thereafter, the Contracting Officer may have the Contractor's invoices or vouchers and statements of cost audited. For cost reimbursement contracts, any payment may be reduced by amounts found by the Contracting Officer not to constitute allowable costs as adjusted for prior overpayment or underpayment. In the event that all payments have been made to the Contractor by the District Government and an overpayment is found, the Contractor shall reimburse the District for said overpayment within thirty (30) days after written notification.

H.15.3 The Contractor shall establish and maintain books, records, and documents (including electronic storage media) in accordance with generally accepted accounting principles and practices which sufficiently and properly reflect all revenues and expenditures of funds provided by the District under the contract that results from this solicitation.

H.15.4 The Contractor shall retain all records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to the contract for a period of five (5) years after termination of the contract, or if an audit has been initiated and audit findings have not been resolved at the end of five (5) years, the records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of the contract.

H.15.5 The Contractor shall assure that these records will be available at all reasonable times for inspection, review, or audit by Federal, District, or other personnel duly authorized by the Contracting Officer.

H.15.6 Persons duly authorized by the Contracting Officer shall have full access to and the right to examine any of the Contractor's contract and related records and documents, regardless of the form in which kept, at all reasonable times for as long as records are retained.

H.15.7 The Contractor shall include these aforementioned audit and record keeping requirements in all approved subcontracts and assignments.

H.16 CONFLICT OF INTEREST

H.16.1 No official or employee of the District of Columbia or the Federal Government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the contract shall, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in the contract or proposed contract. (DC Procurement Practices Act of 1985, D.C. Law 6-85, D.C. Official Code section 2-310.01 and Chapter 18 of the DC Personnel Regulations).

H.16.2 The Contractor represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Contractor further covenants not to employ any person having such known interests in the performance of the contract.

H.17 HIPAA PRIVACY COMPLIANCE

(1) Definitions

(a) *Business Associate*. "Business Associate" shall mean a person or entity, who performs, or assists in the performance of a function or activity on behalf of a covered entity or an organized health care organization in which the covered entity participates, involving the use or disclosure of individually identifiable health information, other than in the capacity of a workforce member of such covered entity or organization. A business associate is also any person or organization that provides, other than in the capacity of a workforce member of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administration, accreditation, or financial services to or for the covered entity and receives individually identifiable health information from a covered entity or another business associate on behalf of a covered entity. In some instances, a covered entity may be a business associate of another covered entity.

(b) *Covered Entity*. "Covered Entity" shall mean District of Columbia Office of Personnel.

(c) *Designated Record Set* means:

A group of records maintained by or for Covered Entity that is:

- (i) The medical records and billing records about individuals maintained by or for a covered health care provider;
- (ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
- (iii) Used, in whole or in part, by or for Covered Entity to make decisions about individuals.

For purposes of this paragraph, the term *record* means any items, collection, or grouping of information that includes Protected Health Information and is maintained, collected, used, or disseminated by or for Covered Entity.

- (d) *Individual* shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).
- (e) *Privacy Rule*. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.
- (f) *Protected Health Information*. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- (g) *Required By Law*. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.501.
- (h) *Secretary*. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

(2) Obligations and Activities of Business Associate

Solicitation DCBE-2007-R-0049
Health Insurance Plan for District Employees

- (a) Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this HIPAA Privacy Compliance Clause (this Clause) or as Required By Law.
 - (b) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Clause.
 - (c) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Clause.
 - (d) Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Clause of which it becomes aware.
 - (e) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
 - (f) Business Associate agrees to provide access, at the request of Covered Entity and within thirty (30) days of the request, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR 164.524.
 - (g) Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR 164.526 at the request of Covered Entity or an Individual, within thirty (30) days of the request.
 - (h) Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity, available to the Covered Entity, or to the Secretary, within thirty (30) days of the request by the Covered Entity, or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
 - (i) Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.
 - (j) Business Associate agrees to provide to Covered Entity or an Individual, within thirty (30) days of a request by the Covered Entity, information collected in accordance with Section (i) above, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.
- (3) Permitted Uses and Disclosures by Business Associate
- (a) *Refer to underlying services agreement:*

Except as otherwise limited in this Clause, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in this Contract provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of Covered Entity.

Solicitation DCBE-2007-R-0049
Health Insurance Plan for District Employees

- (b) Except as otherwise limited in this Clause, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
 - (c) Except as otherwise limited in this Clause, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
 - (d) Except as otherwise limited in this Clause, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR 164.504(e)(2)(i)(B).
 - (e) Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).
- (4) Obligations of Covered Entity
- (a) Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.
 - (b) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.
 - (c) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.
- (5) Permissible Requests by Covered Entity
- Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.
- (6) Term and Termination
- (a) *Term.* The requirements of this HIPAA Privacy Compliance Clause shall be effective as of the date of contract award, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

Solicitation DCBE-2007-R-0049
Health Insurance Plan for District Employees

(b) *Termination for Cause.* Upon Covered Entity's knowledge of a material breach of this Clause by Business Associate, Covered Entity shall either:

- (1) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate the contract if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;
- (2) Immediately terminate the contract if Business Associate has breached a material term of this HIPAA Privacy Compliance Clause and cure is not possible; or
- (3) If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(c) *Effect of Termination.*

- (1) Except as provided in paragraph (2) of this section, upon termination of the contract, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
- (2) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon determination by the Contracting Officer that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

(7) Miscellaneous

- (a) *Regulatory References.* A reference in this Clause to a section in the Privacy Rule means the section as in effect or as amended.
- (b) *Amendment.* The Parties agree to take such action as is necessary to amend this Clause from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Public Law No. 104-191.
- (c) *Survival.* The respective rights and obligations of Business Associate under Section (6) of this Clause and Sections 9 and 20 of the Standard Contract Provisions for use with District of Columbia Government Supply and Services Contracts, effective April 2003, shall survive termination of the contract.
- (d) *Interpretation.* Any ambiguity in this Clause shall be resolved to permit Covered Entity to comply with the Privacy Rule.

SECTION I: CONTRACT CLAUSES

I.1 APPLICABILITY OF STANDARD CONTRACT PROVISIONS

The Standard Contract Provisions for use with District of Columbia Government Supplies and Services Contracts dated March 2007 (“SCP”) are incorporated as part of the contract resulting from this solicitation. To obtain a copy of the SCP go to www.ocp.dc.gov, click on OCP Policies under the heading “Information”, then click on “Standard Contract Provisions – Supplies and Services Contracts”.

I.2 CONTRACTS THAT CROSS FISCAL YEARS

Continuation of this contract beyond the current fiscal year is contingent upon future fiscal appropriations.

I.3 CONFIDENTIALITY OF INFORMATION

All information obtained by the Contractor relating to any employee or customer of the District will be kept in absolute confidence and shall not be used by the Contractor in connection with any other matters, nor shall any such information be disclosed to any other person, firm, or corporation, in accordance with the District and Federal laws governing the confidentiality of records.

I.4 TIME

Time, if stated in a number of days, will include Saturdays, Sundays, and holidays, unless otherwise stated herein.

I.5 RIGHTS IN DATA

I.5.1 “Data,” as used herein, means recorded information, regardless of form or the media on which it may be recorded. The term includes technical data and computer software. The term does not include information incidental to contract administration, such as financial, administrative, cost or pricing, or management information.

I.5.2 The term “Technical Data”, as used herein, means recorded information, regardless of form or characteristic, of a scientific or technical nature. It may, for example, document research, experimental, developmental or engineering work, or be usable or used to define a design or process or to procure, produce, support, maintain, or operate material. The data may be graphic or pictorial delineations in media such as drawings or photographs, text in specifications or related performance or design type documents or computer printouts. Examples of technical data include research and engineering data, engineering drawings and associated lists, specifications, standards, process sheets, manuals, technical reports, catalog item identifications, and related information, and computer software documentation. Technical data does not include

computer software or financial, administrative, cost and pricing, and management data or other information incidental to contract administration.

- I.5.3** The term “Computer Software”, as used herein means computer programs and computer databases. “Computer Programs”, as used herein means a series of instructions or statements in a form acceptable to a computer, designed to cause the computer to execute an operation or operations. "Computer Programs" include operating systems, assemblers, compilers, interpreters, data management systems, utility programs, sort merge programs, and automated data processing equipment maintenance diagnostic programs, as well as applications programs such as payroll, inventory control and engineering analysis programs. Computer programs may be either machine-dependent or machine-independent, and may be general purpose in nature or designed to satisfy the requirements of a particular user.
- I.5.4** The term “computer databases,” as used herein, means a collection of data in a form capable of being processed and operated on by a computer.
- I.5.5** All data first produced in the performance of this Contract shall be the sole property of the District. The Contractor hereby acknowledges that all data are works made for hire and are the sole property of the District; but, to the extent any such data may not, by operation of law, be works made for hire,. The Contractor agrees not to assert any rights in common law or in equity in such data. The Contractor shall not publish or reproduce such data in whole or in part or in any manner or form, or authorize others to do so, without written consent of the District until such time as the District may have released such data to the public.
- I.5.6** The District will have restricted rights in data, including all accompanying documentation, manuals and instructional materials, listed or described in a license or agreement made a part of this contract, which the parties have agreed will be furnished with restricted rights,
- I.5.7** The Contractor shall indemnify and save and hold harmless the District, its officers, agents and employees acting within the scope of their official duties against any liability, including costs and expenses, (i) for violation of proprietary rights, copyrights, or rights of privacy, arising out of the publication, translation, reproduction, delivery, performance, use or disposition of any data furnished under this contract, or (ii) based upon any data furnished under this contract, or based upon libelous or other unlawful matter contained in such data.
- I.5.8** Nothing contained in this clause shall imply a license to the District under any patent, or be construed as affecting the scope of any license or other right otherwise granted to the District under any patent.

I.6 OTHER CONTRACTORS

The Contractor shall not commit or permit any act that will interfere with the performance of work by another District contractor or by any District employee.

I.7 SUBCONTRACTS

The Contractor hereunder shall not subcontract any of the Contractor's work or services to any subcontractor without the prior written consent of the Contracting Officer. Any work or service so subcontracted shall be performed pursuant to a subcontract agreement, which the District will have the right to review and approve prior to its execution by the Contractor. Any such subcontract shall specify that the Contractor and the subcontractor shall be subject to every provision of this contract. Notwithstanding any such subcontract approved by the District, the Contractor shall remain liable to the District for all Contractor's work and services required hereunder.

I.8 INSURANCE

Contractor shall procure and maintain, during the entire period of performance under this contract, the types of insurance specified below. The Contractor shall submit a certificate of insurance giving evidence of the required coverages prior to commencing work. All insurance shall be written with responsible companies licensed by the District of Columbia's Department of Insurance, Securities and Banking. The Contractor shall require all subcontractors to carry the insurance required herein, or Contractor may, at its option, provide the coverage for any or all subcontractors, and if so, the evidence of insurance submitted shall so stipulate. All insurance provided by the Contractor as required by this section, except comprehensive automobile liability insurance, shall set forth the District as an additional named insured. In no event shall work be performed until the required certificates of insurance have been furnished. The insurance shall provide for 30 days' prior written notice to be given to the District in the event coverage is substantially changed, canceled or non-renewed. If the insurance provided is not in compliance with all the requirements herein, the District maintains the right to stop work until proper evidence is provided.

I.8.1 Commercial General Liability Insurance, \$1,000,000 limits per occurrence, District added as an additional insured.

I.8.2 Automobile Liability Insurance, \$1,000,000 per occurrence combined single limit.

I.8.3 Worker's Compensation Insurance according to the statutes of the District of Columbia, including Employer's Liability, \$100,000 per accident for injury, \$100,000 per employee for disease, \$500,000 policy limit disease.

I.8.4 Umbrella/ Excess Liability Insurance, \$5,000,000 limits per occurrence.

I.8.5 Professional Liability Insurance, \$1,000,000 limits per claim (note: such insurance is typically called medical malpractice insurance for doctors, professional liability insurance for lawyers and nurses, and errors and omissions liability insurance for all other "professions" with a professional liability exposure).

I.9 EQUAL EMPLOYMENT OPPORTUNITY

In accordance with the District of Columbia Administrative Issuance System, Mayor's Order 85-85 dated June 10, 1985, the forms for completion of the Equal Employment Opportunity Information Report are incorporated herein as Section J.2.2. An award cannot be made to any offeror who has not satisfied the equal employment requirements.

I.10 ORDER OF PRECEDENCE

Any inconsistency in this solicitation shall be resolved by giving precedence in the following order: the Supplies or Services and Price/Cost Section (Section B), Specifications/Work Statement (Section C), the Special Contract Requirements (Section H), the Contract Clauses (Section I), and the SCP.

I.11 CONTRACTS IN EXCESS OF \$1 MILLION DOLLARS

Any contract in excess of \$1,000,000 shall not be binding or give rise to any claim or demand against the District until approved by the Council of the District of Columbia and signed by the Contracting Officer.

I.12 PRE-AWARD APPROVAL

The award and enforceability of this contract is contingent upon approval of the Council of the District of Columbia.

In accordance with the Council Contract Review Criteria Amendment Act of 1999, D.C. Official Code §2-301.05a, the Mayor must submit to the Council for approval any contract action over one million dollars within a 12-month period.

In accordance with D.C. Official Code §1-301.05a and 1-204.51(c), the Council of the District of Columbia must approve award of any contract that has obligations that extend beyond the fiscal year for which appropriated.

I.13 CONTINUITY OF SERVICES

I.13.1 The Contractor recognizes that the services provided under this contract are vital to the District of Columbia and must be continued without interruption and that, upon contract expiration or termination, a successor, either the District or another contractor, at the District's option, may continue to provide these services. To that end, the Contractor agrees to provide electronic copies of all eligibility and claims information records and files related to the DC Employees Health Benefits Plans it has administered including but not limited to supporting electronic files with individual benefit accumulation data relevant to the provisions of the DC health benefits plans. At the option of the District the Contractor will adjudicate and pay all unpaid claims incurred prior to contract expiration or termination. Contractor's fees for such services will be identified in this RFP in Section B.

I.13.1.1 Furnish phase-out, phase-in (transition) training; and

I.13.1.2 Exercise its best efforts and cooperation to effect an orderly and efficient transition to a successor.

I.13.2 The Contractor shall, upon the Contracting Officer's written notice:

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- I.13.2.1** Furnish phase-in, phase-out services for up to ninety (90) days after this contract expires; and

- I.13.2.2** Negotiate in good faith a plan with a successor to determine the nature and extent of phase-in, phase-out services required. The plan shall specify a training program and a date for transferring responsibilities for each division of work described in the plan, and shall be subject to the Contracting Officer's approval.

- I.13.3** The Contractor shall provide sufficient experienced personnel during the phase-in, phase-out period to ensure that the services called for by this contract are maintained at the required level of proficiency.

- I.13.4** The Contractor shall allow as many personnel as practicable to remain on the job to help the successor maintain the continuity and consistency of the services required by this contract. The Contractor also shall disclose necessary personnel records and allow the successor to conduct on-site interviews with these employees. If selected employees are agreeable to the change, the Contractor shall release them at a mutually agreeable date and negotiate transfer of their earned fringe benefits to the successor.

- I.13.5** In addition to Section I.13.1 and only in accordance with a modification issued by the Contracting Officer, the Contractor shall be reimbursed for all reasonable phase-in, phase-out costs (i.e., costs incurred within the agreed period after contract expiration that result from phase-in, phase-out operations).

SECTION J: LIST OF ATTACHMENTS

J.1 ATTACHMENT

- J.1.1** Wage Determination No.2005-2103, Revision No. 4, dated July 5, 2007
- J.1.2** Current Benefit Plan Designs
- J.1.3** Proposed Benefit Plan Designs
- J.1.4** Monthly Enrollment
- J.1.5** Disruption Analysis (please refer to electronic MSEXcel attachments)
- J.1.6** Census Data (please refer to electronic MSEXcel attachment)
- J.1.7** Monthly Claims (2004- 2007)
- J.1.8** Large Claims Experience (2004-2007)
- J.1.9** District of Columbia Personnel Manual, Chapter 21, which provides the instructions and definitions for TCC
- J.1.10** Health Benefit Enrollment Form (Form 1269)
- J.1.11** Living Wage Notice
- J.1.12** Living Wage Fact Sheet

J.2 INCORPORATED ATTACHMENTS *(The following forms shall be completed and incorporated with the offer.)*

- J.2.1** LSDBE Certification Package (located at www.oldb.dc.gov)
- J.2.2** E.E.O. Information and Mayor' s Order 85-85
(located at www.ocp.dc.gov ; click on Solicitation Attachments)
- J.2.3** Tax Certification Affidavit
(located at www.ocp.dc.gov ; click on Solicitation Attachments)
- J.2.4** First Source Employment Agreement
(located at www.ocp.dc.gov ; click on Solicitation Attachments)
- J.2.5** Cost/Price Data Package
(located at www.ocp.dc.gov ; click on Solicitation Attachments)

SECTION K: REPRESENTATIONS CERTIFICATIONS AND OTHER STATEMENTS OF OFFERORS

K.1 AUTHORIZED NEGOTIATORS

The offeror represents that the following persons are authorized to negotiate on its behalf with the District in connection with this request for proposals: (list names, titles, and telephone numbers of the authorized negotiators).

K.2 TYPE OF BUSINESS ORGANIZATION

K.2.1 The offeror, by checking the applicable box, represents that:

a) It operates as:

- a corporation incorporated under the laws of the State of: _____
- an individual,
- a partnership,
- a nonprofit organization, or
- a joint venture.

b) If the offeror is a foreign entity, it operates as:

- an individual,
- a joint venture, or
- a corporation registered for business in _____
(Country)

K.3 CERTIFICATION AS TO COMPLIANCE WITH EQUAL OPPORTUNITY OBLIGATIONS

Mayor's Order 85-85, "Compliance with Equal Opportunity Obligations in Contracts", dated June 10, 1985 and the Office of Human Rights' regulations, Chapter 11, "Equal Employment Opportunity Requirements in Contracts", promulgated August 15, 1986 (4 DCMR Chapter 11, 33 DCR 4952) are included as a part of this solicitation and require the following certification for contracts subject to the order. Failure to complete the certification may result in rejection of the offeror for a contract subject to the order. I hereby certify that I am fully aware of the content of the Mayor's Order 85-85 and the Office of Human Rights' regulations, Chapter 11, and agree to comply with them in performance of this contract.

Offeror _____ Date _____

Name _____ Title _____

Signature _____

Offeror ____ has ____ has not participated in a previous contract or subcontract subject to the Mayor's Order 85-85. Offeror ____ has ____ has not filed all required compliance reports, and representations indicating submission of required reports signed by proposed subofferors. (The above representations need not be submitted in connection with contracts or subcontracts which are exempt from the Mayor's Order.)

K.4 BUY AMERICAN CERTIFICATION

The offeror hereby certifies that each end product, except the end products listed below, is a domestic end product (See Clause 23 of the SCP, "Buy American Act"), and that components of unknown origin are considered to have been mined, produced, or manufactured outside the United States.

_____ EXCLUDED END PRODUCTS
_____ COUNTRY OF ORIGIN

K.5 DISTRICT EMPLOYEES NOT TO BENEFIT CERTIFICATION

Each offeror shall check one of the following:

_____ No person listed in Clause 13 of the SCP, "District Employees Not To Benefit" will benefit from this contract.

_____ The following person(s) listed in Clause 13 may benefit from this contract. For each person listed, attach the affidavit required by Clause 13 of the SCP.

K.6 CERTIFICATION OF INDEPENDENT PRICE DETERMINATION

a) Each signature of the offeror is considered to be a certification by the signatory that:

1) The prices in this contract have been arrived at independently, without, for the purpose of restricting competition, any consultation, communication, or agreement with any offeror or competitor relating to:

- (a) those prices
- (b) the intention to submit a contract, or
- (c) the methods or factors used to calculate the prices in the contract.

2) The prices in this contract have not been and will not be knowingly disclosed by the offeror, directly or indirectly, to any other offeror or competitor before contract opening unless otherwise required by law; and

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- 3) No attempt has been made or will be made by the offeror to induce any other concern to submit or not to submit a contract for the purpose of restricting competition.
- b) Each signature on the offer is considered to be a certification by the signatory that the signatory;
 - 1) Is the person in the offeror's organization responsible for determining the prices being offered in this contract, and that the signatory has not participated and will not participate in any action contrary to subparagraphs (a)(1) through (a)(3) above; or
 - 2) Has been authorized, in writing, to act as agent for the following principals in certifying that those principals have not participated, and will not participate in any action contrary to subparagraphs (a)(1) through (a)(3) above:

(insert full name of person(s) in the organization responsible for determining the prices offered in this Contract and the title of his or her position in the offeror's organization);
- (a) As an authorized agent, does certify that the principals named in subdivision (b)(2) have not participated, and will not participate, in any action contrary to subparagraphs (a)(1) through (a)(3) above; and
- (b) As an agent, has not participated, and will not participate, in any action contrary to subparagraphs (a)(1) through (a)(3) above.
- c) If the offeror deletes or modifies subparagraph (a)(2) above, the offeror must furnish with its offer a signed statement setting forth in detail the circumstances of the disclosure.

K.7 TAX CERTIFICATION

Each offeror must submit with its offer, a sworn Tax Certification Affidavit, incorporated herein as Attachment J.2.3.

SECTION L: INSTRUCTIONS, CONDITIONS AND NOTICES TO OFFERORS

L.1 CONTRACT AWARD

The District reserves the right to accept/reject any/all bids resulting from this solicitation. The Contracting Officer may reject all bids or waive any minor informality or irregularity in bids received whenever it is determined that such action is in the best interest of the District.

L.1.1 Most Advantageous to the District

The District intends to award multiple contract(s) resulting from this solicitation to the responsible offeror(s) whose offer(s) conforming to the solicitation will be most advantageous to the District, cost or price, technical and other factors, specified elsewhere in this solicitation considered.

L.1.2 Initial Offers

The District may award contracts on the basis of initial offers received, without discussion. Therefore, each initial offer should contain the offeror's best terms from a standpoint of cost or price, technical and other factors.

L.2 PROPOSAL FORM, ORGANIZATION AND CONTENT

One (1) original and five (5) copies of the written proposals shall be submitted in two parts, titled "Technical Proposal" and "Price Proposal." Proposals shall be typewritten in 12 point font size on 8.5" by 11" bond paper. One electronic copy of the proposal (CD ROM) should also be submitted with the disruption analysis and pricing in Excel format, the geo-access summary in Excel format, and other sections in Word format. It is understood that not all attachments will be available electronically. Telephonic, telegraphic, and facsimile proposals will not be accepted. Each proposal shall be submitted in a sealed envelope conspicuously marked: *"Proposal in Response to Solicitation No.: DCBE-2007-R-0049 – Health Insurance Plan for District Employees."*

Offerors are directed to the specific proposal evaluation criteria found in Section M of this solicitation, Evaluation Factors. The offeror shall respond to each factor in a way that will allow the District to evaluate the offeror's response. The offeror shall submit information in a clear, concise, factual and logical manner providing a comprehensive description of program services and service delivery. The information requested below for the technical proposal shall facilitate evaluation and source selection for all proposals. The technical proposal must contain sufficient detail to provide a clear and concise representation of the requirements in the statement of work.

L.2.1 TECHNICAL PROPOSAL

L.2.1.1 Executive Summary

The offeror shall provide an introduction outlining the Offeror's overall technical approach to fulfill the requirements outlined in the RFP. Offerors shall indicate which plan(s) the proposal is being submitted for, using a table similar to the one below.

Plan	Proposal Submitted (Yes/No)
PPO	
POS	
HMO	

L.2.1.2 TECHNICAL QUESTIONNAIRE

The Offeror shall respond to each item listed below. **Where the answer to a question varies by plan (PPO/POS/HMO), the Offeror should clearly state the differences.**

L.2.1.2.1 TAB 1 –TRANSITION PLAN AND EXPERIENCE

Provide an overview of your experience and your plan to transition the District's health insurance plan. Your response should include answers to the specific questions that follow.

1. Name three (3) policyholders of similar size to the District that your company has transitioned to a new health insurance over the past five (5) years. Please provide the name of the company; number of employees; year in which they were transitioned and name and telephone number of a contact person.
 - a. Describe how you ensure your plan will administer the District's benefits including prescription drugs and medical, as requested. Explain any anticipated problem areas.
 - b. Provide a detailed implementation plan that clearly demonstrates the offeror's ability to meet the DC Government's requirements to have a fully functioning program in place and operable on January 1, 2008. This implementation plan should include a list of specific implementation tasks/transition protocols and a time-table for initiation and completion of such tasks, beginning with the contract award and continuing through the effective date of operation (January 1, 2008). The implementation plan should be specific about requirements for information transfer as well as any services or assistance required from the District during implementation. The implementation plan should also specifically identify those individuals, by area of expertise, responsible for key implementation activities and clearly identify their roles. Please label the attachment [**your organizations name. implementation plan**].

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- c. In the transition plan, explain specifically how you will coordinate claims processing. Confirm your ability to comply with the requirement of C.3.1.6
 - d. How will you implement a no loss/no gain takeover on all benefits? By no loss/no gain takeover, the District means that no covered person will lose benefit coverage if they must change benefit plan because a new carrier is awarded the contract. Furthermore, there will be no exclusions for persons previously insured.
 - e. For each plan (PPO/POS/HMO), please provide one federal government, one state government and one private sector reference for the largest organizations for which your company currently provides benefits (include number of employees covered in each case and the current annual premiums, or paid claims amounts if self-funded.) Please provide the names and phone numbers of a contact person for each client. Provide the same information for the three largest organizations your company has lost as a client in the last three years.
2. Provide the following information on your firm including: company name, address and telephone number; date the firm was established; most recent audited financial statement; type of firm (SIC Code).
 - a. Provide the number of participants covered by your PPO, POS, and HMO plans (as applicable) in the Washington D.C. Metropolitan Statistical Area and nationwide. Provide the national number of clients and their total premium income, or paid claims amounts if self-funded, by plan for the calendar years ending 2004, 2005, and 2006. How many clients have you lost in the calendar years 2004, 2005, and 2006? How long have you offered coverage in the Washington Metropolitan Area?
 - b. State any pending regulatory reviews or legal actions that may affect your license to operate. Describe any plans to sell or merge your organization that would affect your relationship with the District.
 3. List key personnel, as defined in H.11, who will be assigned to this requirement. Provide a resume for each person listed. Each resume should show the title, duties and length of service in each position held, including the current position; education; licensure status; and professional associations. Please label the attachment [**your organizations name. resume**].

L.2.1.2.2 TAB 2 - ENROLLMENT ASSISTANCE / WELLNESS PROGRAM

1. The District uses its own enrollment form (Form 1269). See Attachment J.1.11. Provide details if your firm will encounter difficulties in the use of Form 1269. Explain specifically how you will enroll District employees into your plan. What electronic enrollment aids will you make available?

2. Describe how you plan to educate employees about how your plan works and advise them of their rights and responsibilities? Please provide a sample of proposed communication materials.
3. What staff will you make available for District health fairs? Describe how your firm will meet the requirements set forth in C.3.2.3 through C.3.2.7.
4. Describe how you will implement a Wellness Program for the District.

L.2.1.2.3 TAB 3 - PROVIDER QUALIFICATION AND ACCESS

1. Describe your liability coverages, including malpractice, E&O, and total liability. Have there been or are there any judgments or pending complaints for malpractice claims paid by your managed care network(s)? If so, please provide information about the providers involved and size of judgment.
2. Describe how you will provide access for eligible participants residing outside the service area. This also includes benefits for full-time students residing outside of the service area.
3. Describe how many physicians each plan has and how access to these physicians is structured. What percentage of physicians, in your network, accepts new patients? What is the ratio of physicians and specialists to the total enrollees covered by the plan in the Washington D.C. Metropolitan Statistical Area? Do you have established ratios for the number of PPO physicians and/or specialists to the number of enrollees? Please give your target and actual ratios of primary care physicians and specialist to the covered population for your book of business.
4. Provide the following information, which relates to the accessibility of the network:
 - a. A provider network directory that includes identification of any providers who are not currently accepting new patients.
 - b. Provide a GeoAccess report on the following criteria:

Provider	# of Providers	Within # Miles	GeoAccess Method
Physician	2	8	Center of Zip code
Specialist	2	8	Center of Zip code
Hospitals	1	15	Center of Zip code

- c. Complete the following summary reports for the providers listed. In addition to the summary results data below, the Offeror must provide an electronic copy (non-PDF) of the full GeoAccess report with their technical response submission.

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Average Distance to 2 Physician (in miles)	Total number of employees	Number of Employees Matched
Zip Code (200,207,223)		
All other Areas		
Average Distance to 2 Specialist (in miles)	Total number of employees	Number of Employees Matched
Zip Code (200,207,223)		
All other Areas		

Average Distance to 1 Hospital (in miles)	Total number of employees	Number of Employees Matched
Zip Code (200,207,223)		
All other Areas		

5. Provide separate listings of all urgent care centers, accredited institutions used for treatment of drug and/or alcohol dependency and hospitals currently available by 3 digit zip codes 200, 207 and 223.

Zip code (200,207,223)	Urgent Care Centers		
	HMO	POS	PPO
1			
2			
ect			

Zip code (200,207,223)	Hospitals		
	HMO	POS	PPO
1			
2			
ect			

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Zip code (200,207,223) Mental Health/Substance Abuse			
	HMO	POS	PPO
1			
2			
ect			

6. Is your network a newly established product, or is it based on a contracted network? Describe the contracted arrangement.
7. What was the turnover rate for plan physicians for calendar years 2004, 2005, and 2006? For these purposes, turnover rate is defined as the rate at which physicians either left the plan or terminated their participation in the plan. What incentives are used to retain physicians?
8. Are participants free to use any network specialist without a referral? If not, please describe any situation that requires a referral.
9. What are the credentialing criteria used to select providers and what is your process for an annual evaluation for network physicians? Is the level of the physician's fees considered in the selection process? Are patterns of practice considered in the selection process?
10. Do you perform pre-contracting on-site reviews?
11. Define the number of physicians in the network area by specialty. Indicate the number that is board certified.

		Number of Physicians	Number Board Certified
a)	Family Practice		
b)	Internal Medicine		
c)	Pediatricians		
d)	Cardiologists		
e)	Radiologists		
f)	Surgeons (specialties and subspecialties)		
g)	Anesthesiologists		
h)	Mental Health/Substance Abuse practitioners		
i)	Obstetricians		
j)	Other		

12. Describe any special treatment programs, such as centers of excellence, organ transplants, that your organization is associated with noting the names and locations of such centers or facilities.

13. Please describe in detail your plans to reduce or expand your network providers within the next 3 years.
14. What types of ancillary providers are currently included in your networks (such as labs, physical therapists, chiropractors, nursing homes, hospices, acupuncturists)? Provide details of services within the Washington D.C. Metropolitan Statistical Area.
15. How many providers or ancillary caregivers were reprimanded or dismissed during the last twelve (12) months for failure to follow your quality assurance process? If you take a provider out of the network, do you report it to the State licensing authority? How much advance notice do you provide to employees and employer?
16. Would you add a specific hospital, pharmacy, physician or physician group to the network at the request of the District or of an employee? Under what conditions and through what process?
17. How do you define "within the service area" for individual employees (e.g., by employee residence within a certain number of miles of a participating hospital or by a specified driving time)? Describe how a participant is covered for care if he/she is traveling outside the service area.
18. What are the access rules participants must follow for covered services including any referral requirements and required preauthorization by the participant vs. the provider. What are the benefit penalties if not followed?
19. Describe your pharmacy network, with attention to the Washington, DC area. Provide a listing of all pharmacies currently available in the Washington metro area. Please describe in detail your plans to reduce, expand, or change your retail or mail pharmacies within the next 3 years.
20. Describe in detail any arrangements you have with outside firms to provide prescription drug coverage, mental health coverage, optical and dental coverage. For each such relationship, provide the name of the organization and advise how long the arrangements have existed? Describe any plans to change these arrangements in the near future.
21. Please complete Attachment J.1.5, Disruption Report. Please label the attachment **[your organizations name. Disruption Report]**.

L.2.1.2.4 TAB 4 – PLAN AND CLAIMS ADMINISTRATION

1. What is the location of the claim office you propose to use? Is it the same for medical and prescription drugs? Please indicate the location and capacity of the mail order facility being proposed.
2. What is the average response time for claim inquiries? Describe the claims unit that will administer the District's plan (i.e. number of people, processing time, claim accuracy). What is the average turnaround time for written claim inquiries? What is

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- your expected claim turnaround time in work days (on average, for 80% of claims, and for 90% of claims), from date of receipt, for:
- a. Clean claims;
 - b. Coordination of Benefits (COB) claims; and
 - c. Ineligible claims
3. Describe your claim processing process, including the functions that are performed manually by staff and systematically by computers. Include a flowchart that shows the steps employees and payers are to follow. Please label the attachment [**your organizations name. flowchart**]. What procedures are in place to document receipt of claims?
 4. Do claim processors handle inquiries from participants regarding benefit payments, or is there a separate customer service unit to handle such requests?
 5. Please provide a sample claim kit, and several samples of Explanation of Benefits (EOB) forms. Include examples of claim denials and claims coordinated with Medicare. Please label the attachment [**your organizations name. Kit and EOB**].
 6. How are claim disputes handled? Describe your appeal process. What procedures do you have to prevent duplicate billing and ineligible or fraudulent claims?
 7. At what dollar amount do you automatically audit a claim? At what dollar amount must a medical claim payment be approved by supervisory personnel?
 8. What procedure is followed when claim charges exceed expected amounts? Please outline your review procedure.
 9. Do you routinely monitor claim disputes and provider disputes? If so please provide copies of any reports that summarize the results for calendar years 2004, 2005 and 2006. What percentage of claims do you perform quality review? Is the quality review done on a pre-disbursement basis?
 10. How does your company maintain eligibility data? What hours are you available to verify eligibility?
 - a. Does your system maintain a listing of eligible employees/retirees/dependents/TCC on-line? If so, how frequently is the file updated? How often do you update your eligibility listings? Can eligibility be changed instantaneously? If not, how long does it take to update individual records? Is prescription drug eligibility done separately? If so, how long in hours does it take to update prescription drug eligibility?
 11. With respect to COB administration, what procedure do you follow to determine whether other benefits are actually payable? Specifically, can you administer a non-duplication of benefits provision? Is COB administration performed in-house or by

others? If by others, describe the procedure and your relationship with that organization.

12. Describe your ability to coordinate with the Employee Assistance Program (EAP). Have you worked with an employer's EAP in the past? If so, describe.
13. What is the basis used to determine out-of-network covered charges (usual and customary) for reimbursements? How often are they updated? Approximately what percent of billed charges do they represent for hospital inpatient services? For hospital outpatient services? For professional services?

L.2.1.2.5 TAB 5 - QUALITY ASSURANCE

1. Describe your quality assurance program. Describe grievance procedures for plan members and answer the following questions:
 - a. Who is on the grievance committee?
 - b. How many subscriber grievances did you have in 2004, 2005, and 2006?
 - c. How many grievances filed by subscribers have been sustained and resulted in some relief for the subscriber?
2. What ongoing internal quality standards auditing do you perform? Are your internal reports available to the District? What grievance procedures are available for physicians protesting decisions regarding quality assurance issues for subscribers?
3. Do you survey members to determine satisfaction with the services provided by the applicable network? Please discuss method and frequency of the process and provide a summary of the results of the most recent survey. Confirm you will mail the survey to District participants and return the completed surveys to the Contracting Officer's Technical Representative as per C.3.5.1.
4. Please list the most frequent complaints. What remedies were made to improve service? In 2006, how many complaints (per 1,000 members) did you receive?
5. What are your proposed performance guarantees? Include the surveillance method and plan. Confirm the Offeror's understanding that delays or failures in areas such as transition services, enrollment assistance, customer service, provider network access, claims administration or reporting negatively affect the District's and the Contractor's ability to provide critical services to District employees.
6. Attach sample reports that would meet the requirements specified in Section C.3.4 of this RFP. Are these reports available electronically? Describe how and to what extent the District may change these reports. Please label the attachment [**your organization name. reporting**].

L.2.1.2.6 TAB 6 - CARE MANAGEMENT

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Health Insurance Plan for District Employees

1. Please list and describe, in detail, the utilization management and other cost-containment programs available through your company; to what degree are they included in your proposal; and how they would be administered.
 - a. If applicable, do physicians and specialists have incentives to cooperate with outpatient utilization review? How integral is outpatient UR to the practice of medicine for your members?
 - b. If applicable, how are the physicians integrated into the following processes:
 - i. Pre-approval for referrals
 - ii. Concurrent review of ongoing treatments (i.e., chronic care by specialists)
 - iii. Second surgical opinion
2. Provide a complete description of your existing care management systems. Indicate how the programs are administered for network versus out-of-network care. At a minimum, your proposal should address the following:
 - a. Outpatient surgery review
 - b. Medical case management (Is this done on-site or over the telephone?)
 - c. Discharge review
 - d. Hospital pre-admission certification
 - e. Concurrent (continued stay) review
 - f. Second surgical opinion
 - g. Discharge planning
 - h. Short-stay maternity programs
 - i. Bill audits
 - j. Mental health/substance abuse case review
3. Describe any specialized pre-certification, concurrent and retrospective review programs for areas such as mental health/chemical dependency programs. Differentiate as to how this works for network and out-of-network claims. (Is the care management handled differently or by different organizations?)
4. Describe the provisions for second level review when authorization is initially denied.
5. Do you provide case management program? If so, how do you identify and handle cases that require individual case management?
 - a. If such a program is offered, please describe its objectives and procedures. List examples of cases you consider ideal for case management.
 - b. Describe how your nurse line works. What are the hours of operation? Is the nurse line a core service or is there an additional fee?
 - c. Would there be a designated staff for the District? How do you track the participants' medical history/calls? How do you coordinate with other care management?

6. Describe any disease management program and its expected impact on claims.
7. Formulary
 - a. Describe the development of your proposed formulary, including the composition of the committee used in its development.
 - b. What assurance does the District have that the selected drug shall provide a more cost-effective alternative to other drugs?
 - c. Provide an electronic version of your proposed formulary and preferred drug list that includes name, strength, dosage form and 11-digit NDC number for every product on the list.
 - d. What elements are reviewed when determining drugs to be included in the formulary? How often does the formulary change? What is the process for announcing these changes?
8. Provide a complete description of your drug utilization review (DUR) program that is included with your proposal.
9. What percentage of prescriptions written by physicians do you deny annually? Identify the reasons for the denials with the most frequent reason first and the remaining in descending order.
10. Identify any other pharmacy management programs you have included in your proposal.

L.2.1.2.7 ATTACHMENTS & CERTIFICATIONS

Offeror shall provide evidence that it has been granted a Certificate of Authority (COA) by the D.C. Department of Insurance, Securities and Banking (DISB). Offers that fail to include the COA will be considered unacceptable and therefore, will not be reviewed.

Offerors must complete and submit, with their proposals, the required attachments (Attachments J.2.1 through J.2.5) and certifications in Section K.

L.2.2 PRICE PROPOSAL

L.2.2.1 Base Period

Offerors shall submit pricing for all Contract Line Item Numbers (CLINs) in Section B of the solicitation. Offerors must include in the proposed premium rates for CLINs 0002 through 0004, and bank transaction costs referred to in G.3.1 which shall include all costs and charges related to full performance of this contract. For CLIN 0001, the Offeror shall include in the price any costs associated with computer programming that may be required during the start-up period. Offers that fail to provide pricing for each CLIN may be considered unacceptable.

L.2.2.2 Option Rate Formulas and Option Rates

The District requests fixed rates or rate guarantees for the option years. The Offeror shall guarantee the renewal formula(s) or rates to be used in the option years and shall provide the formula with its proposal. The Contractor shall submit option year renewal rates to the Contracting Officer no later than one hundred twenty (120) days prior to the effective date of the renewal.

In providing rate guarantees, the Offeror shall provide the basis of the guarantee, including the assumptions used for which the guarantee is made or will be made; and the guaranteed formula that would apply to each Option Year rate guarantee. For example, Option Year rate guarantees may be (1) on the basis of “Rate Caps” (the maximum amount rates could increase in an Option Year based on enrollment or claims); or (2) on the basis of a renewal formula based on claims experience, trends, and anticipated administrative costs; or (3) some combination of the above. Offers that fail to provide pricing and the supporting calculation for each Option Year may be considered unacceptable.

L.2.2.3 Illustration of Premium Cost

- L.2.2.3.1** The Contractor shall provide a breakdown of premium rates into claims vs. retention. In addition, the contractor shall describe, in detail, the components of retention.
- L.2.2.3.2** The Contractor shall describe the method for calculating the retrospective credit, including the calculation method for incurred claims.
- L.2.2.3.3** The Contractor shall also detail the renewal formula to be used for future years’ rates, including definitions for any terms used in the calculation.
- L.2.2.3.4** Provide an illustrative breakdown of the composite cost components as indicated in the table below:

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Per Enrollee Per Month (PEPM)		HMO	PPO	POS
1	Projected Fee-For-Service Paid Claims			
2	Fee-for-Service Claims Incurred, But Not Reported			
2a.	<i>Current Year Claim Reserve</i>			
2b.	<i>Prior Year Claim Reserve</i>			
2c.	<i>Claim Reserve Adjustment (2a. - 2b.)</i>	\$ -	\$ -	\$ -
3	Projected Incurred Fee-For-Service Claims (1 + 2c.)	\$ -	\$ -	\$ -
4	Capitated Claim Cost			
5	Total Claims Cost (3 + 4)	\$ -	\$ -	\$ -
6	Administration Fees			
6a.	<i>Claims Administration/Payment</i>			
6b.	<i>Customer Service</i>			
6c.	<i>Corporate and Other Overhead</i>			
6d.	<i>Taxes</i>			
6e.	<i>Profit</i>			
6f.	<i>Written, oral and video presentations</i>			
6g.	<i>Employee Meetings/ Health Fairs</i>			
6h.	<i>Utilization Review</i>			
6i.	<i>Care Management</i>			
6j.	<i>Disease Management</i>			
6k.	<i>Member communication materials (ID cards, booklets, open enrollment communications, mailing and postage, etc.)</i>			
6l.	<i>Standard reporting</i>			
6m.	<i>Web-based reporting</i>			
6n.	<i>Member online access</i>			
6o.	<i>Online access to claims data</i>			
6p.	<i>Underwriting and actuarial-related services</i>			
6q.	<i>Meetings with benefits Personnel</i>			
6s.	<i>Other (please specify)</i>			
6t.	<i>Total Administration Fees (Sum of 6a. - 6s.)</i>			
7	Network Access Fees (NAF)			
8	Total Composite Premium Cost (5 + 6t. + 7)	\$ -	\$ -	\$ -

L.2.2.4 Network Savings

L.2.2.4.1 For each applicable Network, what were your discounts off billed charges during 2006 in the DC metropolitan area for:

- a. Hospital Inpatient facility
- b. Hospital Outpatient facility charges
- c. Ancillaries
- d. Professional Services

L.2.2.4.2 For each applicable Network, what are your expected discounts off billed charges during 2007 in the DC metropolitan area for:

- a. Hospital Inpatient facility
- b. Hospital Outpatient facility charges
- c. Ancillaries
- d. Professional Services

L.2.2.4.3 State your dispensing fees and discounts off AWP (or MAC pricing) for:

- a. Retail Generic
- b. Retail Formulary
- c. Retail Non-Formulary
- d. Mail Order Generic
- e. Mail Order Formulary
- f. Mail Order Non-Formulary
- g. Specialty Drugs

L.3 PROPOSAL SUBMISSION DATE AND TIME, AND LATE SUBMISSIONS, LATE MODIFICATIONS, WITHDRAWAL OR MODIFICATION OF PROPOSALS AND LATE PROPOSALS

L.3.1 Proposal Submission

Proposals must be submitted no later than **2:00 PM, Monday, August 20, 2007**. Proposals, modifications to proposals, or requests for withdrawals that are received in the designated District office after the exact local time specified above, are "late" and shall be considered only if they are received before the award is made and one (1) or more of the following circumstances apply:

- (a) The proposal or modification was sent by registered or certified mail not later than the fifth (5th) day before the date specified for receipt of offers;
- (b) The proposal or modification was sent by mail and it is determined by the Contracting Officer that the late receipt at the location specified in the solicitation was caused by mishandling by the District, or
- (c) The proposal is the only proposal received.

L.3.2 Withdrawal or Modification of Proposals

An offeror may modify or withdraw its proposal upon written, telegraphic notice, or facsimile transmission if received at the location designated in the solicitation for submission of proposals, but not later than the closing date for receipt of proposals.

L.3.3 Postmarks

The only acceptable evidence to establish the date of a late proposal, late modification or late withdrawal sent either by registered or certified mail shall be a U.S. or Canadian Postal Service postmark on the wrapper or on the original receipt from the U.S. or Canadian Postal Service. If neither postmark shows a legible date, the proposal, modification or request for withdrawal shall be deemed to have been mailed late. When the postmark shows the date but not the hour, the time is presumed to be the last minute of the date shown. If no date is shown on the postmark, the proposal shall be considered late unless the offeror can furnish evidence from the postal authorities of timely mailing.

L.3.4 Late Modifications

A late modification of a successful proposal, which makes its terms more favorable to the District, shall be considered at any time it is received and may be accepted.

L.3.5 Late Proposals

A late proposal, late modification or late request for withdrawal of an offer that is not considered shall be held unopened, unless opened for identification, until after award and then retained with unsuccessful offers resulting from this solicitation.

L.4 EXPLANATION TO PROSPECTIVE OFFERORS

If a prospective offeror has any questions relative to this solicitation, the prospective offeror shall submit the question in writing to the contact person, identified on page one. The prospective offeror shall submit questions no later than **fifteen (15)** days prior to the closing date and time indicated for this solicitation. The District will not consider any questions received less than **fifteen (15)** days before the date set for submission of proposals. The District will furnish responses promptly to all other prospective offerors. An amendment to the solicitation will be issued if that information is necessary in submitting offers, or if the lack of it would be prejudicial to any other prospective offerors. Oral explanations or instructions given before the award of the contract will not be binding.

L.5 FAILURE TO SUBMIT OFFERS

Recipients of this solicitation not responding with an offer should not return this solicitation. Instead, they should advise the Contracting Officer, Contracting Officer, Group IX, 441 4th Street, NW – Suite 700S, Washington, DC 20001, by letter or postcard whether they want to receive future solicitations for similar requirements. It is also requested that such recipients advise the Contracting Officer, Group IX of the reason for not submitting a proposal in response to this solicitation. If a recipient does not submit an offer and does not notify the

Contracting Officer, Group IX that future solicitations are desired, the recipient's name may be removed from the applicable mailing list.

L.6 RESTRICTION ON DISCLOSURE AND USE OF DATA

L.6.1 Offerors who include in their proposal data that they do not want disclosed to the public or used by the District except for use in the procurement process shall mark the title page with the following legend:

"This proposal includes data that shall not be disclosed outside the District and shall not be duplicated, used or disclosed in whole or in part for any purpose except for use in the procurement process.

If, however, a contract is awarded to this offeror as a result of or in connection with the submission of this data, the District will have the right to duplicate, use, or disclose the data to the extent consistent with the District's needs in the procurement process. This restriction does not limit the District's rights to use, without restriction, information contained in this proposal if it is obtained from another source. The data subject to this restriction are contained in sheets (insert page numbers or other identification of sheets)."

L.6.2 Mark each sheet of data it wishes to restrict with the following legend:

"Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this proposal."

L.7 PROPOSALS WITH OPTION YEARS

The offeror shall include option year prices in its price/cost proposal. An offer may be determined to be unacceptable if it fails to include option year pricing.

L.8 PROPOSAL PROTESTS

Any actual or prospective offeror or contractor who is aggrieved in connection with the solicitation or award of a contract, must file with the D.C. Contract Appeals Board (Board) a protest no later than 10 business days after the basis of protest is known or should have been known, whichever is earlier. A protest based on alleged improprieties in a solicitation which are apparent at the time set for receipt of initial proposals shall be filed with the Board prior to the time set for receipt of initial proposals. In procurements in which proposals are requested, alleged improprieties which do not exist in the initial solicitation, but which are subsequently incorporated into the solicitation, must be protested no later than the next closing time for receipt of proposals following the incorporation. The protest shall be filed in writing, with the Contract Appeals Board, 717 14th Street, N.W., Suite 430, Washington, D.C. 20004. The aggrieved person shall also mail a copy of the protest to the Contracting Officer for the solicitation.

L.9 SIGNING OF OFFERS

The offeror shall sign the offer and print or type its name on the Solicitation, Offer and Award form of this solicitation. Offers signed by an agent shall be accompanied by evidence

of that agent's authority, unless that evidence has been previously furnished to the Contracting Officer.

L.10 UNNECESSARILY ELABORATE PROPOSALS

Unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective response to this solicitation are not desired and may be construed as an indication of the offeror's lack of cost consciousness. Elaborate artwork, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor desired.

L.11 RETENTION OF PROPOSALS

All proposal documents will be the property of the District and retained by the District, and therefore will not be returned to the offerors.

L.12 PROPOSAL COSTS

The District is not liable for any costs incurred by the offerors in submitting proposals in response to this solicitation.

L.13 ELECTRONIC COPY OF PROPOSALS FOR FREEDOM OF INFORMATION ACT REQUESTS

In addition to other proposal submission requirements, the offeror must submit an electronic copy of its proposal, redacted in accordance with any applicable exemptions from disclosure in D.C. Official Code § 2-534, in order for the District to comply with Section 2-536(b) that requires the District to make available electronically copies of records that must be made public. The District's policy is to release documents relating to District proposals following award of the contract, subject to applicable FOIA exemption under Section 2-534(a)(1).

L.14 CERTIFICATES OF INSURANCE

The Contractor shall submit certificates of insurance giving evidence of the required coverages as specified in Section I.8 prior to commencing work. Evidence of insurance shall be submitted within fourteen (14) days of contract award to:

Gena Johnson, Contracting Officer
441 4th Street NW, Suite 700S
Washington, DC 20001
202-727-0252
gena.johnson@dc.gov

L.15 ACKNOWLEDGMENT OF AMENDMENTS

The offeror shall acknowledge receipt of any amendment to this solicitation (a) by signing and returning the amendment; (b) by identifying the amendment number and date in the space provided for this purpose in Section A, Solicitation, Offer and Award form; or (c) by letter or telegram including mailgrams. The District must receive the acknowledgment by

the date and time specified for receipt of offers. Offerors' failure to acknowledge an amendment may result in rejection of the offer.

L.16 BEST AND FINAL OFFERS

If, subsequent to receiving original proposals, negotiations are conducted, all offerors within the competitive range will be so notified and will be provided an opportunity to submit written best and final offers at the designated date and time. Best and Final Offers will be subject to the Late Submissions, Late Modifications and Late Withdrawals of Proposals provision of the solicitation. After receipt of best and final offers, no discussions will be reopened unless the Contracting Officer determines that it is clearly in the District's best interest to do so, e.g., it is clear that information available at that time is inadequate to reasonably justify Contractor selection and award based on the best and final offers received. If discussions are reopened, the Contracting Officer shall issue an additional request for best and final offers to all offerors still within the competitive range.

L.17 LEGAL STATUS OF OFFEROR

Each proposal must provide the following information:

L.17.1 Name, address, telephone number and federal tax identification number of offeror;

L.17.2 A copy of each District of Columbia license, registration or certification that the offeror is required by law to obtain. This mandate also requires the offeror to provide a copy of the executed "Clean Hands Certification" that is referenced in D.C. Official Code §47-2862 (2001), if the offeror is required by law to make such certification. If the offeror is a corporation or partnership and does not provide a copy of its license, registration or certification to transact business in the District of Columbia, the offer shall certify its intent to obtain the necessary license, registration or certification prior to contract award or its exemption from such requirements; and

L.17.3 If the offeror is a partnership or joint venture, the names and addresses of the general partners or individual members of the joint venture, and copies of any joint venture or teaming agreements.

L.18 FAMILIARIZATION WITH CONDITIONS

Offerors shall thoroughly familiarize themselves with the terms and conditions of this solicitation, acquainting themselves with all available information regarding difficulties which may be encountered, and the conditions under which the work is to be accomplished. Contractors will not be relieved from assuming all responsibility for properly estimating the difficulties and the cost of performing the services required herein due to their failure to investigate the conditions or to become acquainted with all information, schedules and liability concerning the services to be performed.

L.19 STANDARDS OF RESPONSIBILITY

The prospective contractor must demonstrate to the satisfaction of the District the capability in all respects to perform fully the contract requirements; therefore, the prospective

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Health Insurance Plan for District Employees

contractor must submit the documentation listed below, within five (5) days of the request by the District.

- L.19.1** Evidence of adequate financial resources, credit or the ability to obtain such resources as required during the performance of the contract.
- L.19.2** Evidence of the ability to comply with the required or proposed delivery or performance schedule, taking into consideration all existing commercial and governmental business commitments.
- L.19.3** Evidence of the necessary organization, experience, accounting and operational control, technical skills or the ability to obtain them.
- L.19.4** Evidence of compliance with the applicable District licensing and tax laws and regulations.
- L.19.5** Evidence of a satisfactory performance record, record of integrity and business ethics.
- L.19.6** Evidence of the necessary production, construction and technical equipment and facilities or the ability to obtain them.
- L.19.7** Evidence of other qualifications and eligibility criteria necessary to receive an award under applicable laws and regulations
- L.19.8** If the prospective contractor fails to supply the information requested, the Contracting Officer shall make the determination of responsibility or nonresponsibility based upon available information. If the available information is insufficient to make a determination of responsibility, the Contracting Officer shall determine the prospective contractor to be nonresponsible.

SECTION M: EVALUATION FACTORS

M.1 EVALUATION FOR AWARD

The contract will be awarded to the responsible offeror(s) whose offer is most advantageous to the District, based upon the evaluation criteria specified below. Thus, while the points in the evaluation criteria indicate their relative importance, the total scores will not necessarily be determinative of the award. Rather, the total scores will guide the District in making an intelligent award decision based upon the evaluation criteria.

M.1.1 The District will evaluate each Plan type separately.

M.2 TECHNICAL RATING

The Technical Rating Scale is as follows:

<u>Numeric Rating</u>	<u>Adjective</u>	<u>Description</u>
0	Unacceptable	Fails to meet minimum requirements; e.g., no demonstrated capacity, major deficiencies which are not correctable; offeror did not address the factor.
1	Poor	Marginally meets minimum requirements; major deficiencies which may be correctable.
2	Minimally Acceptable	Marginally meets minimum requirements; minor deficiencies which may be correctable.
3	Acceptable	Meets requirements; no deficiencies.
4	Good	Meets requirements and exceeds some requirements; no deficiencies.
5	Excellent	Exceeds most, if not all requirements; no deficiencies.

For example, if a sub factor has a point evaluation of 0 to 6 points, and (using the Technical Rating Scale) the District evaluates as "good" the part of the proposal applicable to the sub factor, the score for the sub factor is 4.8 (4/5 of 6). The sub factor scores will be added together to determine the score for the factor level.

M.3 EVALUATION CRITERIA

M.3.1 Technical Criteria

Offeror proposals will be evaluated based on the technical evaluation factors listed in descending order of importance.

M.3.1.1 Plan and Claims Administration

(Total Points Possible: 20 Points)

M.3.1.1.1 Offeror can provide a benefit design that meets the requirements of this solicitation including appropriate benefit features.

M.3.1.1.2 Offeror has demonstrated the ability to effectively process (including managing coordination of benefits), promptly pay, track and audit claims; and manage duplicate billing, disputed, ineligible or fraudulent claims. Offeror has provided an acceptable appeals process and has established a process to facilitate the timely update of eligibility records.

M.3.1.1.3 Offeror has demonstrated its ability to provide a designated customer service and claims unit for District employees.

M.3.1.1.4 Offeror has demonstrated its ability to meet the verification and reporting requirements, maintain a formulary and provide mail order pharmacy access.

M.3.1.2 Provider Qualification and Access

(Total Points Possible: 20 Points)

M.3.1.2.1 Offeror has, as demonstrated by GeoAccess®Reports, a provider network that is accessible to District employees, i.e. 2 physicians with 8 miles of employee residences.

M.3.1.2.2 Offeror has demonstrated its ability to provide covered participants with timely access to network medical providers as evidenced by the percentage of providers that are accepting new patients and limited requirement for referrals. Offeror has demonstrated sufficient access to qualified participating pharmacies. Offeror's network has an adequate number of specialists, hospitals and urgent care centers to service the District's population. Offeror's network includes special treatments programs and ancillary providers.

M.3.1.2.3 Offeror has demonstrated its commitment to enforcing quality standards of the providers in its network as evidenced by the thoroughness of its credentialing/recredentialing process.

M.3.1.2.4 Offeror has demonstrated its ability to attract and maintain providers in its network. Offeror has confirmed its ability to expand its network at the request of the District.

M.3.1.3 Transition Plan & Experience
(Total Points Possible: 15 points)

M.3.1.3.1 Offeror has demonstrated the ability to successfully transition the District's account and administer all benefits, including no gain/no loss and treatments in progress. The Offeror has provided an acceptable implementation plan to educate employees and enroll participants for a plan year to begin January 1, 2008.

M.3.1.3.2 Offeror has, from past performance, transitioned clients to new plans, and has administered plans similar to that described in the solicitation to clients of comparable size to the District. A client of comparable size is one that covers a population equal to at least 85% of the District's estimated population.

M.3.1.3.3 Offeror has, from past performance evaluation of the Offeror, demonstrated a high level of customer service satisfaction from the supplied references, surveys conducted by the Offeror, and other sources known to the District.

M.3.1.3.4 Offeror has presented key personnel information including resumes and certificates demonstrating qualifications and expertise of the Offeror's proposed account teams to meet the requirements of the solicitation.

M.3.1.4 Quality Assurance
(Total Points Possible: 15 Points)

M.3.1.4.1 Offeror has demonstrated its ability and commitment to ensure service quality as evidenced by its Quality Assurance Plan (including grievance procedures and a dispute resolution strategy), the type and number of complaints the Offeror has received, and any service improvements which have been recently implemented.

M.3.1.4.2 Offeror has provided performance guarantees that demonstrate the Offeror's understanding and commitment to providing reliable service. The Offeror understands that delays or failures in areas such as transition services, enrollment assistance, customer service, provider network access, claims administration or reporting negatively affect the District's and the Contractor's ability to provide critical services to District employees.

M.3.1.5 Enrollment Assistance / Wellness Program
(Total Points Possible: 10 Points)

M.3.1.5.1 Offeror has demonstrated the ability and commitment to provide effective communication materials to educate employees about the Plan(s), timely ID cards in accordance with the requirements, and qualified staff to participate in open enrollment session and health fairs. The Offeror has further demonstrated its ability to effectively enroll participants annually.

M.3.1.5.2 Offeror has proposed a comprehensive Wellness Program inclusive of samples of employee communications; a proposed schedule of health fairs and information sessions; and a menu of available alternate educational services.

M.3.1.6 Care Management
(Total Points Possible: 5 Points)

M.3.1.6.1 Offeror has proposed a comprehensive care management program incorporating utilization reviews, a case management program, a disease management program, and other cost-containment programs; and has demonstrated the ability to maximize the efficiency of healthcare delivery without sacrificing quality.

M.3.1.6.2 Offeror utilizes a pharmacy management program that will provide participants with the best value for their prescription drugs needs. Offeror has demonstrated a commitment to controlling prescription drug costs through DUR, appropriate brand substitution policies, and by providing the highest level of discounts that are reasonably possible for prescription drugs and provides credit on all rebates. Offeror has presented an effective plan to timely notify participants of any changes in the formulary.

M.3.2 PRICE CRITERIA

The price evaluation will be objective. The Offeror with the lowest estimated total price for the base and option years will receive the maximum price points. All other proposals will receive a proportionately lower total score. The following formula will be used to determine each Offeror's evaluated price score:

$$\frac{\text{Lowest Total Estimated Price (base + option yrs)}}{\text{Total Estimated Price (base + option yrs of proposal being evaluated)}} \times 15 = \text{Evaluated Price Score}$$

M.3.3 LSDBE PREFERENCE POINTS (Maximum 12 Points)

M.3.4 TOTAL MAXIMUM POINTS = 112

M.4 EVALUATION OF OPTION YEARS

The District will evaluate offers for award purposes by evaluating the total price for all options, based on the proposed fixed rates or rate guarantees for the option years, as well as the base year. Evaluation of options shall not obligate the District to exercise them. The total District's requirements may change during the option years. Quantities to be awarded will be determined at the time each option is exercised.

M.5 Preferences for Local Businesses, Disadvantaged Businesses, Resident-owned Businesses, Small Businesses, Longtime Resident Businesses, or Local Businesses with Principal Offices Located in an Enterprise Zone

Under the provisions of the "Small, Local, and Disadvantaged Business Enterprise Development and Assistance Act of 2005" (the Act), Title II, Subtitle N, of the "Fiscal Year 2006 Budget Support Act of 2005", D.C. Law 16-33, effective October 20, 2005, the District shall apply preferences in evaluating bids or proposals from businesses that are

small, local, disadvantaged, resident-owned, longtime resident, or local with a principal office located in an enterprise zone of the District of Columbia.

M.5.1 General Preferences

For evaluation purposes, the allowable preferences under the Act for this procurement are as follows:

- M.5.1.1** Three percent reduction in the bid price or the addition of three points on a 100-point scale for a small business enterprise (SBE) certified by the Small and Local Business Opportunity Commission (SLBOC) or the Department of Small and Local Business Development (DSLBD), as applicable;
- M.5.1.2** Three percent reduction in the bid price or the addition of three points on a 100-point scale for a resident-owned business enterprise (ROB) certified by the SLBOC or the DSLBD, as applicable;
- M.5.1.3** Ten percent reduction in the bid price or the addition of ten points on a 100-point scale for a longtime resident business (LRB) certified by the SLBOC or the DSLBD, as applicable;
- M.5.1.4** Two percent reduction in the bid price or the addition of two points on a 100-point scale for a local business enterprise (LBE) certified by the SLBOC or the DSLBD, as applicable ;
- M.5.1.5** Two percent reduction in the bid price or the addition of two points on a 100-point scale for a local business enterprise with its principal office located in an enterprise zone (DZE) and certified by the SLBOC or the DSLBD, as applicable; and
- M.5.1.6** Two percent reduction in the bid price or the addition of two points on a 100-point scale for a disadvantaged business enterprise (DBE) certified by the SLBOC or the DSLBD, as applicable.

M.5.2 Application of Preferences

The preferences shall be applicable to prime contractors as follows:

- M.5.2.1** Any prime contractor that is an SBE certified by the SLBOC or the DSLBD, as applicable, will receive a three percent (3%) reduction in the bid price for a bid submitted by the SBE in response to an Invitation for Bids (IFB) or the addition of three points on a 100-point scale added to the overall score for proposals submitted by the SBE in response to a Request for Proposals (RFP).
- M.5.2.2** Any prime contractor that is an ROB certified by the SLBOC or the DSLBD, as applicable, will receive a three percent (3%) reduction in the bid price for a bid submitted by the ROB in response to an IFB or the addition of three points on a 100-point scale added to the overall score for proposals submitted by the ROB in response to an RFP.

- M.5.2.3** Any prime contractor that is an LRB certified by the SLBOC or the DSLBD, as applicable, will receive a ten percent (10%) reduction in the bid price for a bid submitted by the LRB in response to an IFB or the addition of ten points on a 100-point scale added to the overall score for proposals submitted by the LRB in response to an RFP.
- M.5.2.4** Any prime contractor that is an LBE certified by the SLBOC or the DSLBD, as applicable, will receive a two percent (2%) reduction in the bid price for a bid submitted by the LBE in response to an IFB or the addition of two points on a 100-point scale added to the overall score for proposals submitted by the LBE in response to an RFP.
- M.5.2.5** Any prime contractor that is a DZE certified by the SLBOC or the DSLBD, as applicable, will receive a two percent (2%) reduction in the bid price for a bid submitted by the DZE in response to an IFB or the addition of two points on a 100-point scale added to the overall score for proposals submitted by the DZE in response to an RFP.
- M.5.2.6** Any prime contractor that is a DBE certified by the SLBOC or the DSLBD, as applicable, will receive a two percent (2%) reduction in the bid price for a bid submitted by the DBE in response to an IFB or the addition of two points on a 100-point scale added to the overall score for proposals submitted by the DBE in response to an RFP.

M.5.3 Maximum Preference Awarded

Notwithstanding the availability of the preceding preferences, the maximum total preference to which a certified business enterprise is entitled under the Act for this procurement is twelve percent (12%) for bids submitted in response to an IFB or the equivalent of twelve (12) points on a 100-point scale for proposals submitted in response to an RFP. There will be no preference awarded for subcontracting by the prime contractor with certified business enterprises.

M.5.4 Preferences for Certified Joint Ventures

When the SLBOC or the DSLBD, as applicable, certifies a joint venture, the certified joint venture will receive preferences as a prime contractor for categories in which the joint venture and the certified joint venture partner are certified, subject to the maximum preference limitation set forth in the preceding paragraph.

M.5.5 Vendor Submission for Preferences

- M.5.5.1** Any vendor seeking to receive preferences on this solicitation must submit at the time of, and as part of its bid or proposal, the following documentation, as applicable to the preference being sought:

M.5.5.1.1 Evidence of the vendor's or joint venture's certification by the SLBOC as an SBE, LBE, DBE, DZE, LRB, or RBO, to include a copy of all relevant letters of certification from the SLBOC; or

M.5.5.1.2 Evidence of the vendor's or joint venture's provisional certification by the DSLBD as an SBE, LBE, DBE, DZE, LRB, or RBO, to include a copy of the provisional certification from the DSLBD.

M.5.5.2 Any vendor seeking certification or provisional certification in order to receive preferences under this solicitation should contact the:

Department of Small and Local Business Development
ATTN: LSDBE Certification Program
441 Fourth Street, N.W., Suite 970N
Washington, DC 20001

M.5.5.3 All vendors are encouraged to contact the DSLBD at (202) 727-3900 if additional information is required on certification procedures and requirements.

M.6 EVALUATION OF PROMPT PAYMENT DISCOUNT

M.6.1 Prompt payment discounts shall not be considered in the evaluation of offers. However, any discount offered will form a part of the award and will be taken by the District if payment is made within the discount period specified by the offeror.

M.6.2 In connection with any discount offered, time will be computed from the date of delivery of the supplies to carrier when delivery and acceptance are at point of origin, or from date of delivery at destination when delivery, installation and acceptance are at that, or from the date correct invoice or voucher is received in the office specified by the District, if the latter date is later than date of delivery. Payment is deemed to be made for the purpose of earning the discount on the date of mailing of the District check.