

AWARD / CONTRACT		1. This Contract is a rated order under DPAS 9 (15 CFR 700)	Rating DO-C9	Page 1	of Pages 79
2. Contract (Proc., Inst., Ident.) No. H9400210D0001		3. Effective Date Oct 16, 2009	4. Requisition / Purchase Request / Project No. 09-CMB-0332		
5. Issued By DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY/CM 16401 E. CENTRETECH PARKWAY AURORA, CO 80011-9066		Code H94002	6. Administered By (if other than item) See Item 5		Code H94002

7. Name and address of Contractor (No., Street, City, state and Zip Code) INTERNATIONAL SOS ASSISTANCE, INC. 3600 HORIZON BLVD, SUITE 300 TREVOSE PA 19053		Vendor ID: 00000340 DUNS: 020411393 CEC: Cage Code: IPS09 TIN: 911501877	8. Delivery <input type="checkbox"/> FOB Origin <input type="checkbox"/> Other (See below)
Code		Facility Code	9. Discount for prompt payment Net 30
11. Ship To / Mark For DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY/CM 16401 E. CENTRETECH PARKWAY AURORA, CO 80011-9066		Code H94002	10. SUBMIT INVOICES (4 copies unless otherwise specified) Address shown in: Item

11. Ship To / Mark For DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY/CM 16401 E. CENTRETECH PARKWAY AURORA, CO 80011-9066		Code H94002	12. Payment will be made by DEPARTMENT OF DEFENSE (RMF) FINANCE AND ACCOUNTING BRANCH 16401 E. CENTRETECH PARKWAY AURORA, CO 80011-9066		Code RMF
13. Authority for using other than full and open competition <input type="checkbox"/> 10 U.S.C 2304C() <input type="checkbox"/> 41 U.S.C. 253 (C)()		14. Accounting and Appropriation Data			

15A ITEM NO.	15B SUPPLIES/SERVICES	15C QUANTITY	15D UNIT	15E UNIT PRICE	15F AMOUNT
See Next Page - Schedule B - Line Items					
If all options are exercised, Estimated Value is \$269,052,427.00					

15G. TOTAL AMOUNT OF CONTRACT \$ 0.00

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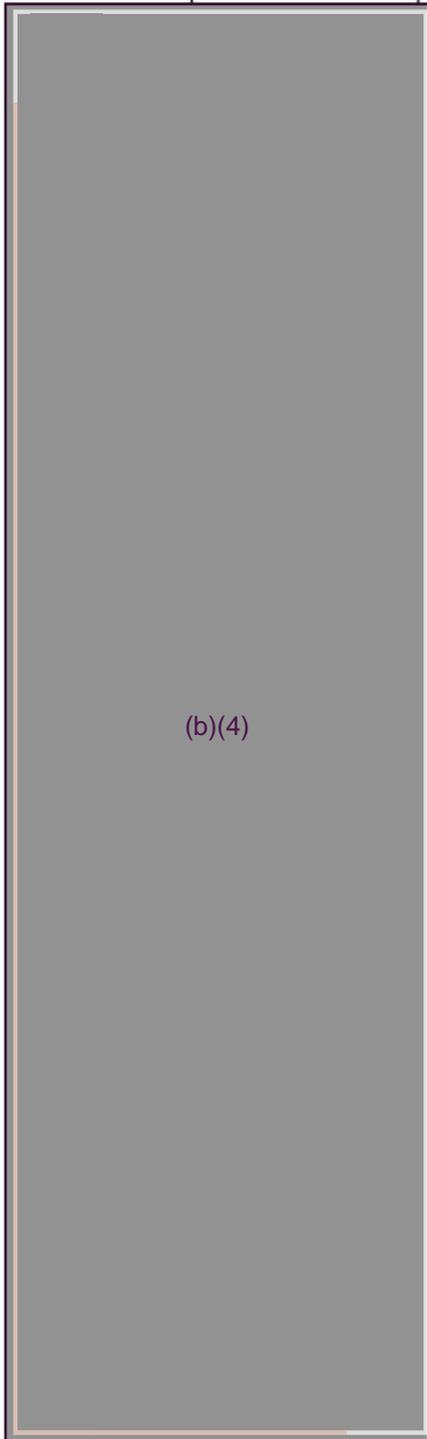
Contracting Officer will complete item 17 or 18 as applicable

17. <input type="checkbox"/> CONTRACTOR'S NEGOTIATED AGREEMENT (Contractor is required to sign this document and return _____ copies to issuing office.) Contractor agrees to furnish and deliver all items or perform all the services set forth or otherwise identified above and on any continuation sheets for the consideration stated herein. The rights and obligation of the parties to this contract shall be subject to and governed by the following documents: (a) this award/contract, (b) the solicitation, if any, and (c) such provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. (Attached are listed herein.)	18. <input type="checkbox"/> AWARD (Contractor is not required to sign this document.) Your offer on Solicitation number _____ including the additions or changes made by you which additions or changes are set forth above, is hereby accepted as to the items listed above and on any continuation sheets. This award consummates the contract which consists of the following documents: (a) the Government's solicitation and your offer, and (b) this award/contract. No further contractual document is necessary.
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19A. Name and Title of Signer (Type or Print) NICHOLAS PETERS, PRESIDENT & CEO INTERNATIONAL SOS ASSISTANCE INC	20A. Name of Contracting Officer THOMAS L GRIFFIN 303-676-3823 tom.griffin@tma.osd.mil
19B. Name of Contractor By _____ (Signature of person authorized to sign)	20B. United States of America By Thomas L Griffin (Signature of Contracting Officer)
19C. Date Signed 10/20/09	20C. Date Signed 10/21/09

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
	BASE YEAR - Period of Performance 01 November 2009 through 31 August 2010				
0001	TRANSITION IN Planning and Implementation of Transitioning In as stated in the Statement of Work, Section C-7.12. of the contract. Per Lot (LT).	1	LT		
0002	DIACAP CERTIFICATION Administrative and Support cost associated with providing the services as stated in the Statement of Work, Section C-7.8.4. and C-7.9.8. of the contract. Per Lot (LT).	1	LT		
0003	TRANSITION IN REPORTS/PLANS, CONTRACT DATA REQUIREMENTS LIST (DD Form 1423) Reports/Plans as stated in Section F of the Contract. Per Lot (LT).	1	LT		
	OPTION PERIOD 1 - Period of Performance 01 September 2010 through 31 August 2011				
1001	MANAGED CARE FEE - PRIME ENROLLED MEMBERS Administrative and Support costs associated with providing the services as stated in the Statement of Work, Section C-7. of the contract for the enrolled population. Per Member Per Month (PMPM). Estimated Quantities.	3871656	MM		
1002	CLAIMS PROCESSING FEE Administrative and Support costs associated with providing the services as stated in the Statement of Work, Section C-7.8. of the contract for Active Duty Service Members (ADSM), Active Duty Family Members (ADFM), Retirees, and Dependents of Retirees. Per Claim (CL). Estimated Quantities.	650000	CL		
1003	TRANSIENT CARE MANAGEMENT Administrative and Support costs associated with providing the services for Urgent/Emergency care as stated in the Statement of Work, Section C- 1.3.2., Section C-1.3.3., and Section C-1.3.4. of the contract for non-enrolled Active Duty Service Members (ADSM) in an authorized leave status, TAD/TDY, deployed to the area, or Prime Enrolled Active Duty Family Members (ADFM). Per Case (CS).	2000	CS		



(b)(4)

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
1004	TRANSLATION SERVICES Translation Services as stated in the Statement of Work, Section C-7.2.5. of the contract. Per Page (PG).	700	PG	(b)(4)	
1005	DISEASE MANAGEMENT Disease Management as stated in the Statement of Work, Section C-7.3.5. of the contract.	0	CS		
1005AA	Disease Management for Cancer Screening	3013	CS		
1005AB	Disease Management for Specific Disease States	930	CS		
1006	SEMIANNUAL AWARD FEE Semiannual Award Fee as stated in the Statement of Work, Section H-8. of the contract. Per Lot (LT). Total Award Fee for Option Period 1 = (b)(4)	1	LT		
1006AA	SEMIANNUAL AWARD FEE NO. 1: 1 September 2010 through 28 February 2011. Per Each (EA).	1	EA		
1006AB	SEMIANNUAL AWARD FEE NO. 2: 1 March 2011 through 31 August 2011. Per Each (EA).	1	EA		
1007	INCENTIVE FEE Incentive Fee as stated in the Statement of Work, Section H-6. of the contract. Per Lot (LT).	1	LT		
1008	REPORTS/PLANS, CONTRACT DATA REQUIREMENTS LIST (DD Form 1423) Reports/Plans as stated in Section F of the contract. Per Lot (LT).	1	LT		
1009	CONTRACT ADMINISTRATION CLIN Contract Administration CLIN for Administration of Contract Modifications and Change Orders. Per Lot (LT).	1	LT		
1010	TRANSITION OUT Planning and Implementation of Transitioning Out as stated in the Statement of Work, Section C-7.12. of the contract. Per Lot (LT).	1	LT		
	OPTION PERIOD 2 - Period of Performance 01 September 2011 through 31 August 2012				

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
2001	MANAGED CARE FEE - PRIME ENROLLED MEMBERS Administrative and Support costs associated with providing the services as stated in the Statement of Work, Section C-7. of the contract for the enrolled population. Per Member Per Month (PMPM).	3871656	MM		
2002	CLAIMS PROCESSING FEE Administrative and Support costs associated with providing the services as stated in the Statement of Work, Section C-7.8. of the contract for Active Duty Service Members (ADSM), Active Duty Family Members (ADFM), Retirees, and Dependents of Retirees. Per Claim (CL).	650000	CL		
2003	TRANSIENT CARE MANAGEMENT Administrative and Support costs associated with providing the services for Urgent/Emergency care as stated in the Statement of Work, Section C-1.3.2., Section C-1.3.3., and Section C-1.3.4. of the contract for non-enrolled Active Duty Service Members (ADSM) in an authorized leave status, TAD/TDY, deployed to the area, or Prime Enrolled Active Duty Family Members (ADFM). Per Case (CS).	2070	CS		
2004	TRANSLATION SERVICES Translation Services as stated in the Statement of Work, Section C-7.2.5. of the contract. Per Page (PG).	700	PG	(b)(4)	
2005	DISEASE MANAGEMENT Disease Management as stated in the Statement of Work, Section C-7.3.5. of the contract.	0	LT		
2005AA	Disease Management for Cancer Screening	3013	CS		
2005AB	Disease Management for Specific Disease States	930	CS		
2006	SEMIANNUAL AWARD FEE Semiannual Award Fee as stated in the Statement of Work, Section H-8. of the contract. Per Lot (LT). Total Award Fee for Option Period 2 =	1	LT		
	(b)(4)				
2006AA	SEMIANNUAL AWARD FEE NO. 3: 1 September 2011 through 29 February 2012. Per Each (EA).	1	EA		
2006AB	SEMIANNUAL AWARD FEE NO. 4: 1 March 2012 through 31 August 2012. Per Each (EA).	1	EA		

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
2007	INCENTIVE FEE Incentive Fee as stated in the Statement of Work, Section H-6. of the contract. Per Lot (LT).	1	LT		
2008	REPORTS/PLANS, CONTRACT DATA REQUIREMENTS LIST (DD Form 1423) Reports/Plans as stated in Section F of the contract. Per Lot (LT).	1	LT		
2009	CONTRACT ADMINISTRATION CLIN Contract Administration CLIN for Administration of Contract Modifications and Change Orders. Per Lot (LT).	1	LT		
2010	TRANSITION OUT Planning and Implementation of Transitioning Out as stated in the Statement of Work, Section C-7.12. of the contract. Per Lot (LT). OPTION PERIOD 3 - Period of Performance 01 September 2012 through 31 August 2013	1	LT		
3001	MANAGED CARE FEE - PRIME ENROLLED MEMBERS Administrative and Support costs associated with providing the services as stated in the Statement of Work, Section C-7. of the contract for the enrolled population. Per Member Per Month (PMPM).	3871656	MM		(b)(4)
3002	CLAIMS PROCESSING FEE Administrative and Support costs associated with providing the services as stated in the Statement of Work, Section C-7.8. of the contract for Active Duty Service Members (ADSM), Active Duty Family Members (ADFM), Retirees, and Dependents of Retirees. Per Claim (CL).	650000	CL		
3003	TRANSIENT CARE MANAGEMENT Administrative and Support costs associated with providing the services for Urgent/Emergency care as stated in the Statement of Work, Section C-1.3.2., Section C-1.3.3., and Section C-1.3.4. of the contract for non-enrolled Active Duty Service Members (ADSM) in an authorized leave status, TAD/TDY, deployed to the area, or Prime Enrolled Active Duty Family Members (ADFM). Per Case (CS).	2142	CS		
3004	TRANSLATION SERVICES Translation Services as stated in the Statement of Work, Section C-7.2.5. of the contract. Per Page	700	PG		

Supplies or Services and Prices/Costs

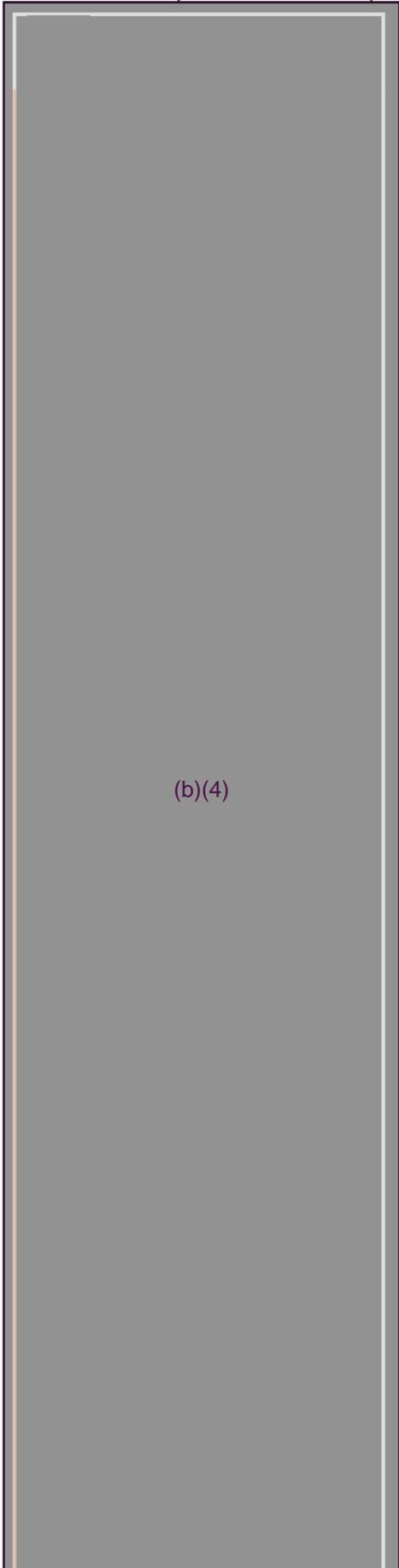
Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
	(PG).				
3005	DISEASE MANAGEMENT Disease Management as stated in the Statement of Work, Section C-7.3.5. of the contract.	0	LT		
3005AA	Disease Management for Cancer Screening	3013	CS		
3005AB	Disease Management for Specific Disease States	930	CS		
3006	SEMIANNUAL AWARD FEE Semiannual Award Fee as stated in the Statement of Work, Section H-8. of the contract. Per Lot (LT). Total Award Fee for Option Period 3 = (b)(4)	1	LT		
3006AA	SEMIANNUAL AWARD FEE NO. 5: 1 September 2012 through 28 February 2013. Per Each (EA).	1	EA		
3006AB	SEMIANNUAL AWARD FEE NO. 6: 1 March 2013 through 31 August 2013. Per Each (EA).	1	EA		
3007	INCENTIVE FEE Incentive Fee as stated in the Statement of Work, Section H-6. of the contract. Per Lot (LT).	1	LT		(b)(4)
3008	REPORTS/PLANS, CONTRACT DATA REQUIREMENTS LIST (DD Form 1423) Reports/Plans as stated in Section F of the contract. Per Lot (LT).	1	LT		
3009	CONTRACT ADMINISTRATION CLIN Contract Administration CLIN for Administration of Contract Modifications and Change Orders. Per Lot (LT).	1	LT		
3010	TRANSITION OUT Planning and Implementation of Transitioning Out as stated in the Statement of Work, Section C-7.12. of the contract. Per Lot (LT).	1	LT		
	OPTION PERIOD 4 - Period of Performance 01 September 2013 through 31 August 2014				
4001	MANAGED CARE FEE - PRIME ENROLLED MEMBERS Administrative and Support costs associated with providing the services as stated in the Statement of	3871656	MM		

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
	Work, Section C-7. of the contract for the enrolled population. Per Member Per Month (PMPM).				
4002	CLAIMS PROCESSING FEE Administrative and Support costs associated with providing the services as stated in the Statement of Work, Section C-7.8. of the contract for Active Duty Service Members (ADSM), Active Duty Family Members (ADFM), Retirees, and Dependents of Retirees. Per Claim (CL).	650000	CL	(b)(4)	
4003	TRANSIENT CARE MANAGEMENT Administrative and Support costs associated with providing the services for Urgent/Emergency care as stated in the Statement of Work, Section C-1.3.2., Section C-1.3.3., and Section C-1.3.4. of the contract for non-enrolled Active Duty Service Members (ADSM) in an authorized leave status, TAD/TDY, deployed to the area, or Prime Enrolled Active Duty Family Members (ADFM). Per Case (CS).	2217	CS		
4004	TRANSLATION SERVICES Translation Services as stated in the Statement of Work, Section C-7.2.5. of the contract. Per Page (PG).	700	PG		
4005	DISEASE MANAGEMENT Disease Management as stated in the Statement of Work, Section C-7.3.5. of the contract.	0	LT		
4005AA	Disease Management for Cancer Screening	3013	CS		
4005AB	Disease Management for Specific Disease States	930	CS		
4006	SEMIANNUAL AWARD FEE Semiannual Award Fee as stated in the Statement of Work, Section H-8. of the contract. Per Lot (LT). Total Award Fee for Option Period 4 = (b)(4)	1	LT		
4006AA	SEMIANNUAL AWARD FEE NO. 7: 1 September 2013 through 28 February 2014. Per Each (EA).	1	EA		
4006AB	SEMIANNUAL AWARD FEE NO. 8: 1 March 2014 through 31 August 2014. Per Each (EA).	1	EA		
4007	INCENTIVE FEE Incentive Fee as stated in the Statement of Work, Section H-6. of the contract. Per Lot (LT).	1	LT		

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
4008	REPORTS/PLANS, CONTRACT DATA REQUIREMENTS LIST (DD Form 1423) Reports/Plans as stated in Section F of the contract. Per Lot (LT).	1	LT		
4009	CONTRACT ADMINISTRATION CLIN Contract Administration CLIN for Administration of Contract Modifications and Change Orders. Per Lot (LT).	1	LT		
4010	TRANSITION OUT Planning and Implementation of Transitioning Out as stated in the Statement of Work, Section C-7.12. of the contract. Per Lot (LT).	1	LT		
	OPTION PERIOD 5 - Period of Performance 01 September 2014 through 31 August 2015				
5001	MANAGED CARE FEE - PRIME ENROLLED MEMBERS Administrative and Support costs associated with providing the services as stated in the Statement of Work, Section C-7. of the contract for the enrolled population. Per Member Per Month (PMPM).	3871656	MM		
5002	CLAIMS PROCESSING FEE Administrative and Support costs associated with providing the services as stated in the Statement of Work, Section C-7.8. of the contract for Active Duty Service Members (ADSM), Active Duty Family Members (ADFM), Retirees, and Dependents of Retirees. Per Claim (CL).	650000	CL		
5003	TRANSIENT CARE MANAGEMENT Administrative and Support costs associated with providing the services for Urgent/Emergency care as stated in the Statement of Work, Section C-1.3.2., Section C-1.3.3., and Section C-1.3.4. of the contract for non-enrolled Active Duty Service Members (ADSM) in an authorized leave status, TAD/TDY, deployed to the area, or Prime Enrolled Active Duty Family Members (ADFM). Per Case (CS).	2295	CS		
5004	TRANSLATION SERVICES Translation Services as stated in the Statement of Work, Section C-7.2.5. of the contract. Per Page (PG).	700	PG		
5005	DISEASE MANAGEMENT	0	LT		



(b)(4)

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
	Disease Management as stated in the Statement of Work, Section C-7.3.5. of the contract.				
5005AA	Disease Management for Cancer Screening	3013	CS	(b)(4)	
5005AB	Disease Management for Specific Disease States	930	CS		
5006	SEMIANNUAL AWARD FEE Semiannual Award Fee as stated in the Statement of Work, Section H-8. of the contract. Per Lot (LT). Total Award Fee for Option Period 5 = (b)(4)	1	LT		
5006AA	SEMIANNUAL AWARD FEE NO. 9: 1 September 2014 through 28 February 2015. Per Each (EA).	1	EA		
5006AB	SEMIANNUAL AWARD FEE NO. 10: 1 March 2015 through 31 August 2015. Per Each (EA).	1	EA		(b)(4)
5007	INCENTIVE FEE Incentive Fee as stated in the Statement of Work, Section H-6. of the contract. Per Lot (LT).	1	LT		
5008	REPORTS/PLANS, CONTRACT DATA REQUIREMENTS LIST (DD Form 1423) Reports/Plans as stated in Section F of the contract. Per Lot (LT).	1	LT		
5009	CONTRACT ADMINISTRATION CLIN Contract Administration CLIN for Administration of Contract Modifications and Change Orders. Per Lot (LT).	1	LT		
5010	TRANSITION OUT Planning and Implementation of Transitioning Out as stated in the Statement of Work, Section C-7.12. of the contract. Per Lot (LT).	1	LT		

SECTION C
DESCRIPTION/SPECIFICATIONS/WORK STATEMENT

C-1. GENERAL

C-1.1. The purpose of this contract is to provide health care support services to the Department of Defense (DoD) TRICARE Overseas Program (TOP) in locations outside the 50 United States and the District of Columbia. The Contractor shall assist the TOP Regional Director, TRICARE Area Office (TAO) Directors, and Military Treatment Facility (MTF) Commanders in operating an integrated health care delivery system which effectively combines the resources of the military's direct medical care system with the Contractor's health care support services.

C-1.2. Section C includes two categories of outcome based statements. The "Statement of Objectives" represents the outcomes for this contract. The objectives are supported by "Technical Requirements." These requirements represent specific tasks, outcomes, and/or standards that, at a minimum, must be achieved.

C-1.3. The scope of this contract includes the following:

C-1.3.1. Health care support services (including coverage for medical/surgical benefits identified in the TRICARE Policy Manual) and claims processing for TOP Prime and TOP Prime Remote-enrolled beneficiaries and all other TRICARE beneficiaries residing in the locations identified at Section F-3 (to include TRICARE Standard, TRICARE for Life, and TRICARE Reserve Select), regardless of where the care is received. Not all beneficiaries receive the same health care support services (e.g., certain services are only offered to TOP enrollees). Claims for MTF-referred supplemental health care are within the scope of this contract, but is not a current contract requirement (see C-7.8.19). The Contractor shall establish host nation network provider agreements and other business processes to ensure that authorized health care services are provided to TOP Prime and TOP Prime Remote-enrolled beneficiaries on a "cashless, claimless" basis. "Cashless, claimless" is defined as an encounter with a provider who collects only normal TRICARE copayments from the beneficiary at the time of service and agrees to file the claim for the beneficiary.

C-1.3.2. Urgent and emergent health care support services and claims processing for active duty service members (ADSMs) who are in a temporary duty status (TDY/TAD), in an authorized leave status, deployed, or deployed on liberty in the locations identified at Section F-3 where MTF care is not available, regardless of their actual TRICARE enrollment location or permanent residence address. Authorized health care services for these ADSMs shall be provided on a cashless, claimless basis.

C-1.3.3. Urgent and emergent health care support services and claims processing for beneficiaries who are enrolled or reside in the 50 United States and the District of Columbia, and who receive health care in an overseas location (as identified at Section F-3), regardless of their actual TRICARE enrollment location or permanent residence address. This does not apply to beneficiaries enrolled to the Uniformed Services Family Health Plan (USFHP) or the Continued Health Care Benefit Program (CHCBP).

C-1.3.4. Urgent and emergent health care support services and claims processing for all TRICARE Prime-enrolled active duty family members (ADFMs) who are traveling in a remote overseas location where MTF care is not available, regardless of their actual TRICARE enrollment location or permanent residence address. Emergency health care support services for these ADFMs shall be provided on a cashless, claimless basis.

C-1.3.5. Dental care services and claims processing for ADSMs permanently assigned to a remote overseas location, and urgent/emergent dental care services for ADSMs who are TDY/TAD, in an authorized leave status, deployed, or deployed

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SECTION C
DESCRIPTION/SPECIFICATIONS/WORK STATEMENT

on liberty in remote overseas locations, regardless of their actual TRICARE enrollment location or permanent residence address. Authorized dental care services for these ADSMs shall be provided on a cashless, claimless basis.

C-2. **STATEMENT OF OBJECTIVES.** The objectives of this contract are as follows:

C-2.1. Objective 1 - Claims Processing. Timely and accurate processing of all TRICARE claims that fall within the scope of the contract, to include full compliance with TRICARE's requirements for development, processing, medical review, authorization, and data record submission.

C-2.2. Objective 2 - Beneficiary and Provider Satisfaction. Beneficiary and provider satisfaction at the highest level possible throughout the period of performance, through the delivery of world-class health care as well as customer friendly program services. Beneficiaries and providers must be satisfied with the services provided by the Contractor.

C-2.3. Objective 3 - Host Nation Provider Services. Development and management of host nation provider networks (complemented by non-network providers) capable of providing access to the full range of TRICARE covered benefits and services, to include (but not limited to) medical/surgical benefits, mental health services, durable medical equipment, pharmaceuticals, and dental care (for remote active duty service members). Host nation network providers shall be certified in accordance with recognized licensure/certification/medical malpractice insurance standards for their location.

C-2.4. Objective 4 - Management. Provision of administrative, management, and customer support services, to include appropriate staffing levels, incorporating commercial practices when practicable to ensure efficient and effective management of all aspects of the contract.

C-2.5. Objective 5 - Transitions. Fully operational services and systems at the start of health care delivery with minimal disruption to beneficiaries, providers, and MTFs.

C-3. **DOCUMENTS**

C-3.1. The following documents, including any and all changes thereto, are hereby incorporated by reference and made a part of the contract. These documents form an integral part of this contract. Documentation incorporated into this contract by reference has the same force and effect as if set forth in full text. Except for Title 10, United States Code (U.S.C.), Chapter 55, these documents are located at: <http://manuals.tricare.osd.mil>.

C-3.1.1. Title 10, U.S.C., Chapter 55

C-3.1.2. 32 Code of Federal Regulations (CFR), Part 199

C-3.1.3. TRICARE Policy Manual (TPM) 6010.57-M, February 1, 2008 (through Change 03). Specific TOP policy is located in Chapter 12.

C-3.1.4. TRICARE Reimbursement Manual (TRM) 6010.58-M, February 1, 2008 (through Change 03).

C-3.1.5. TRICARE Operations Manual (TOM) 6010.56-M, February 1, 2008 (through Change 03). Specific TOP operational guidance is located in Chapter 24.

C-3.1.6. TRICARE Systems Manual (TSM) 7950.2-M, February 1, 2008 (through Change 03).

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C-3.1.7. The TRICARE Manuals provide instruction, guidance and responsibilities in addition to the requirements set forth in the incorporated federal statutes and regulations and may be interpreted in contradiction thereto. Among the Manuals, the TPM takes precedence over the other three TRICARE Manuals. The TRM takes precedence over the TSM and the TOM. The TSM takes precedence over the TOM.

C-3.2. Government Standards required by TRICARE Operations Manual, exceeded by Contractor performance guarantees, are hereby superceded as follows:

Contractor Guarantee	Superceded Government Standard	Reference
(b)(4) of all calls answered within 30 seconds.	90% within 30 seconds.	TOM CH 1 S 3
(b)(4) of all Retained and Adjusted Claims completed within 21 days.	85% within 21 days.	TOM CH 24 S 9
(b)(4)	80% to 97% over life of contract.	TOM CH 1 S 3
(b)(4) Block Calls	< 5%.	TOM CH 1 S 3
(b)(4) Priority Correspondence completed within 10 days.	85% within 10 days.	TOM CH 1 S 3
(b)(4) Pre Authorizations within 2 working days.	90% within 2 work days.	TOM CH 1 S 3
100% Pre Authorizations within 4 days.	100% within 5 days.	TOM CH 1 S 3
(b)(4) Referral Authorization Requests within 2 working days.	90% within 2 work days.	TOM CH 1 S 3
100% Non-Expedited Medical Necessity Reconsiderations within (b)(4) days.	100% within 90 days.	TOM CH 1 S 3

C-4. DEFINITIONS. Definitions are included in 32 CFR 199.2 and the TOM, Appendix B.

C-5. GOVERNMENT FURNISHED PROPERTY AND SERVICES

C-5.1. At certain MTFs and TAO offices, facility space and Government Furnished Equipment may be provided for Contractor personnel. This may include information management hardware and software to allow the Contractor to access the Armed Forces Health Longitudinal Technology Application (AHLTA) and other Government systems. Space and equipment to be provided by the Government at the MTFs and TAO offices (including estimated workload) is described in Attachment J-9, Government-Furnished Space and Equipment/Enrollment and Marketing Workload. FAR 52.245-1, Government Furnished Property (GFP), describes the Contractor's management responsibilities and use of GFP. The GFP is provided in an "as-is" condition and subject to terms discussed in the referenced FAR clause. The GFP inventory will be identified in the MTF and TAO Director Memorandums of Understanding (MOUs) prepared by the Contractor during the transition-in phase of the contract.

C-5.2. In support of the Government's educational initiatives, the Government will furnish educational materials for use in informing interested parties of the program. These materials shall be provided according to the MOU that shall be established between the Contractor and TRICARE Management Activity (TMA) Communications and Customer Service Directorate (see C-7.7.2).

C-6. CONTRACTOR FURNISHED ITEMS. The Contractor shall furnish all necessary items (e.g., facilities, labor, services, supplies, etc.) not provided by the Government (as specifically identified under Section C-4 or elsewhere within the

SECTION C
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contract as Government furnished) for the satisfactory performance of this contract.

C-7. TECHNICAL REQUIREMENTS. The Contractor must fulfill the following requirements, which are supplemented via the documents incorporated at paragraph C-2.

C-7.1. HOST NATION PROVIDERS

C-7.1.1. The Contractor shall provide a managed, stable, high-quality network or networks of individual and institutional host nation providers which promotes access, quality, beneficiary and provider satisfaction, and "best value health care" for TOP enrollees in the MTF and remote locations identified in Attachments J-2 and J-3 (see TOM, Appendix B, for definition of "best value health care"). In MTF locations, host nation provider networks shall be developed to support TOP Prime enrollees by complementing the clinical services that are available in the MTF. In remote locations, host nation provider networks shall be developed to provide primary and specialty care to TOP Prime Remote enrollees, as well as dental care services to certain ADSMs (see C-1.3.5). When necessary, the Contractor shall augment host nation provider network(s) with non-network providers to ensure that the number, mix, and geographic distribution of host nation providers is sufficient to provide all TRICARE reimbursable services under this contract to TOP enrollees in all MTF and remote areas identified in Attachments J-2 and J-3, unless otherwise determined and agreed to in writing by the Contracting Officer to not be practicable. The Contractor's host nation provider network(s) shall also support the requirements of special programs described in the TPM and the TOM (e.g., the Extended Care Health Option (ECHO)) for TOP enrollees. The Contractor shall provide copies of network provider agreements when requested by the Contracting Officer (CO) or the Contracting Officer Representative (COR).

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C-7.1.2. The Contractor shall make their best effort to ensure that the TRICARE standards for access, in terms of beneficiary travel time, local community standards, appointment wait time, and office wait time for various categories of services contained in 32 CFR 199.17 are met for TOP Prime and TOP Prime Remote enrollees. The Contractor shall inform the Government of locations where access to care is severely impaired (in terms of beneficiary travel time, appointment wait time, and/or office wait time) and shall work in a collaborative and partnering manner with the Government to improve access in these areas.

C-7.1.3. The Contractor shall ensure that host nation network and non-network provider capabilities and capacities can be adjusted as necessary to compensate for changes in MTF capabilities and capacities (due to facility downsizing or closure, MTF expansion, establishment of new clinics, provider deployment or reassignment, etc.), which may change frequently over the life of the contract. The Contractor shall adjust the capabilities and capacities of available host nation providers to compensate for such changes when and where they occur within 90 calendar days of notification by the Government.

C-7.1.4. One measure of network adequacy or inadequacy shall be the percentage of paid claims for TOP Prime and TOP Prime Remote enrollees that are submitted by network providers, after excluding claims for Point of Service (POS), Other Health Insurance (OHI), pharmaceuticals and emergency care. The Contractor shall ensure that host nation provider networks are sufficient in number, mix, and geographic distribution to achieve the Contractor's target of 80% for the percentage of paid claims for TOP Prime and TOP Prime Remote enrollees submitted by network providers during Option Period 1. This percentage of network claims shall increase by an additional 2% per option period for Option Periods 2 and 3, and shall increase by an additional 1% per option period for the remainder of

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the contract as described in Section H-6.4. Claims for TOP Prime and TOP Prime Remote shall be analyzed separately. Network inadequacy is defined as any failure to achieve at least the above stated thresholds (to include the Contractor's target for Option Period 1 and the Government's target for all subsequent Option Periods) for TOP Prime or TOP Prime Remote claims. The Contractor shall assess network adequacy on an ongoing basis, and shall inform the Government of any instances of network inadequacy. Network adequacy reports shall be submitted within 30 calendar days after contract award and every 30 calendar days thereafter. The Contractor will submit a corrective action plan for instances of network inadequacy that are significant (e.g., the only specialist in a certain specialty leaves the network) or likely to persist for more than 30 calendar days. The Contractor shall respond to any inquiries from the Government concerning any aspect of network adequacy from a Contracting Officer (Procuring Contracting Officer or Administrative Contracting Officer), Contracting Officer's Representative (COR), TOP Regional Director, or TAO Director within two working days.

C-7.1.5. In the absence of specific reimbursement rates mandated by TMA, the Contractor may negotiate reimbursement rates with host nation providers. The Contractor may also negotiate rates in locations where TMA has directed a specific reimbursement rate; however, the negotiated rate cannot exceed the TMA-directed rate. The Contractor shall maintain copies of all documents used to establish the reasonable and customary local reimbursement rates, and shall make these documents available for Government inspection upon request.

C-7.1.6. The Contractor shall establish and operate a provider certification/recertification program to ensure that all host nation providers who provide services to TRICARE beneficiaries are qualified to provide high quality of care that is commensurate with host nation requirements. This program shall track and monitor the credentials of all health care providers working under this contract, including the individual provider credentials, credentialing organization, date of credentials and date of credentials expiration. Network providers must meet the medical malpractice insurance standards for their host nation (if any). Also, the Contractor shall check the DHHS Sanction List during the certification/recertification process for all host nation providers (See <http://www.oig.hhs.gov/fraud/exclusions/listofexcluded.html>). Providers listed on the DHHS Sanction List are excluded from providing services under all federal programs. This restriction remains in place even if a provider begins practicing in another country. Credentials for network providers shall be verified during the network development/network agreement process. When required by TMA, credentials for non-network providers shall be verified upon receipt of the first TRICARE claim from a non-network host nation provider, and prior to payment of the claim. Primary source verification may include verification performed by host nation Governmental/licensing bodies, certification (as applicable), and licensure, as well as evaluating the provider's office to determine hygiene, appropriate health care setting, and that universal infection control procedures are in place. Network providers shall be able to communicate in English, both orally and in writing, or provide translation services at the time of service. The Contractor shall submit information on all providers authorized by the Contractor, to the TRICARE Management Activity centralized TRICARE Encounter Provider Records (TEPRV) system in accordance with the provisions of the TRICARE Systems Manual.

C-7.1.6.1. The Contractor shall perform on-site verification during provider certification in the Philippines. The Government may expand this on-site verification requirement to other locations during the life of the contract.

C-7.1.7. Network hospitals and other places of institutional care shall meet accreditation standards of the specific host nation. The Contractor shall establish processes to evaluate host nation institutions and maintain such

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evaluations for inspection by the Government. Evaluations shall be updated every three years at a minimum. Any changes in a facility's accreditation status, ownership, etc. shall be reported immediately to the appropriate TRICARE Area Office (TAO).

C-7.1.8. The Contractor shall have an active provider education program designed to enhance and maintain host nation provider awareness of applicable TRICARE requirements, policies, and procedures to allow them to carry out the requirements of this contract in an efficient and effective manner that promotes beneficiary and provider satisfaction. The Contractor will produce regional provider education material that must be reviewed and approved by the Government. (b)(4)

languages: German, Italian, Korean, Japanese, Arabic, Spanish, and Turkish. The Government will provide mandatory formats for all Contractor-produced regional educational material to ensure that all TRICARE marketing products have a consistent look and feel and are appropriate for that specific region. A detailed description of the Contractor's provider education program shall be incorporated into the Contractor's network development plan, which is due no later than 180 calendar days prior to the start of health care delivery. Following Government approval of the methodology, the Contractor shall implement and maintain the program. Distribution of initial marketing materials to network providers shall occur no earlier than 60 calendar days and no later than 30 calendar days prior to the start of health care delivery. Ongoing provider education efforts shall be in accordance with the Government-approved plan.

C-7.1.9. The Contractor shall ensure that authorized health care services are provided on a cashless, claimless basis to TOP Prime and TOP Prime Remote enrollees. Cashless, claimless services shall also be available to beneficiaries identified in C-1.3.2 (for urgent and emergent care only), C-1.3.4 (for emergent care only), and C-1.3.5 (for urgent and emergent dental care only, unless the ADSM is permanently assigned to a remote overseas location).

C-7.1.10. The Contractor is responsible for determining the medical malpractice coverage required in the country, province, state, etc., (including country, province, state, etc., risk pools if applicable) for each network provider (both professional and institutional) and ensuring that each network provider is in compliance with this standard. In the absence of country, province, state, etc., law requirement for medical malpractice insurance coverage, the Contractor is responsible for determining the local community standard for medical malpractice coverage, and the Contractor must maintain the documentation evidencing both the standard and compliance by network providers. In all cases, a network provider must have medical malpractice coverage, except for providers that are country, province, state, etc., entities and are self-insured by the country, province, state, etc. The Contractor agrees to be liable for and expressly agrees to indemnify the Government for any liability resulting from services provided under the contract to MHS eligible beneficiaries for care provided by Contractor network providers, or, in the alternative, the Contractor agrees that all network provider agreements used by the Contractor shall contain a requirement, directly or indirectly by reference to applicable regulations or TMA policies, that the provider agrees to indemnify the Government from any liabilities arising from any acts or omissions in the provision of medical services by the provider to MHS eligible beneficiaries for care provided by Contractor network providers. Each network provider agreement must indicate the required malpractice coverage. Evidence documenting the required coverage of each network provider under the contract shall be provided to the Contracting Officer upon request. The Contracting Officer retains the authority to determine whether country, province, state, etc., and/or local requirements and/or community standards for medical malpractice coverage have been met by a network provider and whether the Contractor has documented the required coverage. The Contractor shall provide the Government with a listing of the

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requirements for, and the availability of malpractice insurance in all countries included in the Scope of Work.

C-7.1.11. The Contractor shall maintain an accurate, readily accessible, up-to-date list identifying all network providers, including their specialty, subspecialty, gender, work address, work fax number, and work telephone number for each service area, and whether or not they are accepting new TRICARE patients. The Contractor shall provide easy access to this list via a user-friendly World Wide Web site and any other means established at the Contractor's discretion. The information contained in an electronic list shall be current within the last 30 calendar days. All network provider lists shall include a brief statement geared specifically towards TOP enrollees, advising them of appropriate referral/authorization processes and the possible consequences of self-referral for specialty care.

C-7.1.12. The Contractor shall identify any Contractor-owned facilities providing health care to TOP enrollees and shall work cooperatively with the Government to develop a plan to mitigate the appearance of a potential general conflict of interest.

C-7.2. REFERRAL MANAGEMENT

C-7.2.1. The Contractor shall operate a referral management program for specialty and inpatient services provided to TOP Prime and TOP Prime Remote enrollees. In MTF locations (Attachment J-2), the MTF has first right of refusal for all referrals. First right of refusal is defined as providing the MTF with an opportunity to review each referral from a civilian provider to determine if the MTF has the capability and capacity to provide the care. When care cannot be provided by an MTF within the TRICARE access standards, or in remote areas where an MTF is not available, the Contractor shall ensure that required care is authorized and delivered by a qualified host nation network or non-network provider. The Contractor shall provide health care finder services, locate an appropriate network or non-network provider to provide the authorized services, and inform the beneficiary of the referral authorization. Upon beneficiary request, the Contractor shall facilitate making the appointment with the host nation provider. All authorized care provided to TOP Prime and TOP Prime Remote enrollees shall be provided on a cashless, claimless basis. The Contractor shall establish Guarantee of Payment or other business processes to fulfill this requirement.

C-7.2.2. The Contractor's referral management program shall also be available to ADSMs not enrolled to TOP Prime or TOP Prime Remote, who are temporarily assigned, deployed, deployed on liberty, or in an authorized leave status and who require urgent or emergent care overseas. These beneficiaries should seek authorization from the TOP Contractor prior to receiving urgent care in an overseas location (emergency care never requires preauthorization). The Contractor shall ensure that these ADSMs receive authorized urgent care and emergent care on a cashless, claimless basis. Upon beneficiary request, the Contractor shall assist the beneficiary in scheduling an appointment with the appropriate host nation provider.

C-7.2.3. The Contractor's referral management program shall also be available to ADFMs who are enrolled in TRICARE Prime in the 50 United States and the District of Columbia, and who require urgent or emergent health care services while traveling through or visiting an overseas location. These beneficiaries should seek authorization from the TOP Contractor prior to receiving urgent care in an overseas location (emergency care never requires preauthorization). The Contractor shall ensure that these ADFMs receive emergency care on a cashless, claimless basis. Upon beneficiary request, the Contractor shall assist the beneficiary in scheduling an appointment with the appropriate host nation provider.

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C-7.2.4. The Contractor's referral management processes shall include a provision for evaluating the referred service to determine if the type of service is a covered TRICARE benefit, and informing the beneficiary prior to the visit in the event the requested service is not a TRICARE benefit. This does not apply to referrals for ADSMs. This shall not be a medical necessity or preauthorization review; rather, this process shall be a customer service/provider relations function providing an administrative coverage review. This service shall be accomplished for every non-ADSM referral received by the Contractor, regardless of whether it was generated by an MTF, network provider, or non-network provider.

C-7.2.5. The Contractor shall provide medical record translation services for TOP Prime Remote-enrolled active duty service members (ADSMs) upon request in accordance with TOM Chapter 24, Section 26. Documents to be translated should be consistent with medical documents that are routinely included in the military health record, including provider treatment notes, laboratory results/radiology results, hospitalization and operative summaries, provider letters summarizing care received, and emergency care records. The contractor shall not translate medical bills, blank medical forms, preprinted patient educational or instructional material, or documents older than 365 calendar days (unless specifically directed by the Contracting Officer). Translations shall be accomplished within 10 workdays of receipt.

C-7.3. MEDICAL MANAGEMENT

C-7.3.1. The Contractor shall ensure that care provided, including mental health care, is medically necessary and appropriate. The Contractor shall use its best practices in managing, reviewing and authorizing health care services. The Contractor shall comply with the provisions of 32 CFR 199.4, 199.5 and the TRICARE Policy Manual when reviewing and approving medical care, unless a specific exception or variation has been authorized by TMA to accommodate the significant cultural differences that affect the overseas health care environment. The Contractor's medical management program shall incorporate the primary care management program contained in 32 CFR 199.17. This program shall ensure that beneficiaries efficiently and effectively receive medically necessary and appropriate primary care and authorized preventive services.

C-7.3.2. The Contractor shall be considered a multi-function Peer Review Organization (PRO) under this contract and shall follow all standards, rules, and procedures as defined in 32 CFR 199.15. The Contractor, using its authority as a PRO, shall apply its own utilization management practices to inpatient care received by MTF enrollees in a host nation setting consistent with MTF referral instructions. The Contractor shall fax a copy (or by other electronic means addressed in each MTF MOU) of these utilization management decisions to the MTF Commander the day the decision is made.

C-7.3.3. Utilization Management. The Contractor shall offer a utilization management program to ensure that a beneficiary's clinical needs are being fulfilled at the most cost-effective, clinically appropriate setting. This program shall be available to all beneficiaries identified in C-1.3. This program shall exclude TRICARE-Medicare dual eligible beneficiaries when they receive care in the Commonwealth of Puerto Rico, Guam, American Samoa, the Northern Marianas, and the United States Virgin Islands. The Contractor's utilization management program shall incorporate strategies for reducing or eliminating inappropriate utilization (e.g., reducing length of stay, identifying and using less expensive care sites when clinically appropriate, decreasing readmissions, etc.). In developing utilization management strategies, the Contractor shall allow for significant cultural differences unique to foreign countries and their health care practices. No later than 90 calendar days prior to the start of health care delivery, the Contractor shall

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propose their utilization management program and patient selection criteria for review and approval by the Contracting Officer prior to implementation. This plan shall also be submitted annually thereafter, no later than 90 calendar days prior to the start of each option period. At a minimum, the Contractor's program shall assess the following for possible utilization management:

C-7.3.3.1. Patients with paid claims in excess of \$5,000 for non-institutional care, or \$10,000 for institutional care per fiscal year.

C-7.3.3.2. Patients with more than 10 claims per fiscal year for the same diagnosis or related diagnoses.

C-7.3.3.3. Patients with more than 10 total inpatient days per fiscal year.

C-7.3.4. Case Management. The Contractor shall offer a case management program designed to identify and manage the health care of individuals with high-cost conditions or with specific diseases or conditions for which evidence-based clinical management programs exist. This program shall be available to TRICARE eligible beneficiaries (both enrolled and non-enrolled) who are authorized to receive reimbursement for civilian health care per 32 CFR 199, and active duty personnel whose care occurs or is projected to occur in whole or in part in the civilian sector. This program shall exclude TRICARE-Medicare dual eligible beneficiaries who receive care in the Commonwealth of Puerto Rico, Guam, American Samoa, the Northern Marianas, and the United States Virgin Islands. The Contractor shall accept and evaluate referrals from any source for potential case management of patients for whom improved health status and quality of care may be enhanced over the long term. The MTF retains primary responsibility for case management for MTF enrollees; however, the contractor shall provide assistance to the MTF in the identification and management of MTF enrollees who could benefit from case management. When care occurs outside an MTF for an MTF-enrolled beneficiary, the Contractor is responsible for coordinating the care with the MTF clinical staff as well as the civilian providers. The Contractor shall propose their Case Management Program Plan and patient selection criteria for review by the Contracting Officer prior to implementation (no later than 90 calendar days prior to the start of health care delivery) and annually thereafter (no later than 90 calendar days prior to the start of each option period). At a minimum, the Contractor's program shall assess the following for possible case management:

C-7.3.4.1. Head Trauma - All ICD-9-CM codes with the first three digits of 852, 853, and 854

C-7.3.4.2. Spinal Cord Injuries - All ICD-9-CM codes with the first three digits of 806

C-7.3.4.3. Human Immunodeficiency Virus Infection (AIDS) - All ICD-9-CM codes with the first three digits of 042

C-7.3.4.4. Neoplasms - All V58.1 ICD-9-CM code cases

C-7.3.4.5. All neonates admitted to a Neonatal Intensive Care Unit

C-7.3.4.6. Bone Marrow - All ICD-9-CM procedure codes beginning with 41.0

C-7.3.4.7. Burns - All ICD-9-CM codes beginning with 948

C-7.3.5. Disease Management. The Contractor shall operate a Disease Management Program for TOP Prime Remote enrollees in accordance with TOM Chapter 24, Section 6. Disease management conditions will be asthma, diabetes, cancer screening, depression and anxiety disorders, and hypertension. The Contractor shall submit a Disease Management Program Plan, required under Section F-7.1.6,

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describing the Contractor's guidelines, protocols, and intervention(s), along with detailed accounting and reporting on the cost and performance of the Disease Management Program. The Contractor's plan shall include program information that will be provided to the Government, which when combined with other Government generated data will allow for effective evaluation of the Disease Management Program. The plan and cost estimate are subject to review and concurrence by the Contracting Officer prior to implementation and annually thereafter.

C-7.3.6. Medical Evacuation. When medically necessary and appropriate, the Contractor shall arrange for medical evacuation for TOP Prime and TOP Prime Remote enrollees; ADSMs who are deployed, in a temporary duty status, or in an authorized leave status in an overseas location; and TRICARE Prime-enrolled ADFMs who are traveling in a remote overseas location. The Contractor shall coordinate patient movement with the responsible TRICARE Area Office(s) and the appropriate military transport agency (GPMRC, TPRMC-E or TPRMC-W). Government resources for medical evacuation must first be exhausted, followed by commercial resources, with private, chartered ground and/or air evacuation as a last resort. Such transportation may include, but is not limited to, air ambulance, helicopter, and ground vehicles (ambulance and/or other suitable means). The Contractor shall ensure that all available medical records accompany the patient during medical evacuation. Medical evacuation services for all beneficiaries listed in this section shall be provided on a cashless, claimless basis to the nearest MTF or host nation facility that is capable of providing the needed services within the medically appropriate time frame. See TOM Chapter 24, Section 7 and Attachment J-4, Regional Patient Movement Procedures.

C-7.3.6.1. Upon request, the Contractor shall provide limited assistance regarding medical evacuation for other TRICARE eligible beneficiaries not identified in Section C-7.3.6. (regardless of enrollment location or residence), including the identification of military, commercial, or private sources for air ambulance, helicopter, and ground ambulance services for the beneficiary's location. The Contractor is responsible for claims processing for these beneficiaries; however, the Contractor is not required to provide medical evacuation services to these beneficiaries on a cashless, claimless basis. See TOM Chapter 24, Section 7 and Attachment J-4, Regional Patient Movement Procedures.

C-7.3.6.2. The Contractor may request use of a Government Supply Source pursuant to FAR 52.251-1 to facilitate medical evacuations from locations where commercial sources for aviation fuel are unavailable. Such requests should be submitted as soon as the supply shortfall is identified to avoid delays in movement of patients requiring emergent care. At a minimum, the Contractor shall request authorization to use a Government Supply Source to purchase Defense Energy Support Center (DESC) aviation fuel from Diego Garcia.

C-7.3.6.3. In the event the Government cancels an authorized medical evacuation for a beneficiary identified in Section C-7.3.6. after the Contractor has arranged for this service, the following process will apply. The Contractor shall retain for records and future reviews, all documentation to support reimbursement of associated costs resulting from the Government's decision to cancel the evacuation. The documentation shall include the steps the Contractor followed (as outlined in TOM Chapter 24, Section 7 and Attachment J-4, Regional Patient Movement Procedures), including when and how the Contractor was notified to perform the medical evacuation. Additionally, the documentation should include all communications between the Contractor and the provider(s) involved in performing the evacuation, as well as all communications from the Government representative cancelling the evacuation. The Contractor shall submit a claim for these costs, coded A0998 (ambulance response and treatment, no transport).

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C-7.3.7. Medical Transfers. The Contractor shall coordinate the care and transfer of TOP Prime and TOP Prime Remote enrollees; ADSMs who are deployed, in a temporary duty status, or in an authorized leave status in an overseas location; and TRICARE Prime-enrolled ADFMs who are traveling in a remote overseas location when these beneficiaries are stabilized patients who require a transfer from one location to another. Transfers from one overseas location to another overseas location shall include coordination with the appropriate TRICARE Area Office(s), coordinating with the primary clinicians at the losing and gaining sites, ensuring that medical records accompany the patient, coordinating with the patient's family, arranging medically appropriate patient transport, ensuring all necessary supplies are available during the transport and at the receiving location, arranging for and ensuring the presence of all necessary medical equipment and/or medical personnel during transport and at the receiving location, and identifying and ensuring the availability of necessary resources to accomplish the transfer. Transfers from an overseas location to a location in the 50 United States and the District of Columbia shall include coordination between the Contractor and the appropriate Managed Care Support Contractor to ensure that the transfer is accomplished in an efficient and effective manner. Medical transfers shall be provided on a cashless, claimless basis for TOP Prime and TOP Prime Remote enrollees; ADSMs who are deployed, in a temporary duty status, or in an authorized leave status in an overseas location; and TRICARE Prime-enrolled ADFMs who are traveling in a remote overseas location.

C-7.3.7.1. Upon request, the Contractor shall provide limited assistance regarding patient transfer for other TRICARE eligible beneficiaries not identified in Section C-7.3.7. (regardless of enrollment location or residence), including the identification of patient transfer organizations and health care providers/institutions in the patient's area. The Contractor is responsible for claims processing for these beneficiaries; however, the Contractor is not required to provide patient transfer services to these beneficiaries on a cashless, claimless basis. See Attachment J-4, Regional Patient Movement Procedures.

C-7.3.8. Notification of Case. The Contractor shall notify the appropriate MTF Commander (for TOP Prime enrollees) or TAO Director (for TOP Prime Remote enrollees) within 12 hours of notification of enrollee hospitalization in a host nation facility. The Notification of Case information to be provided, and the methods of communicating this information, will be addressed in the MTF and TAO MOUs with the Contractor.

C-7.3.9. Clinical Quality Management Program (CQMP). The offeror shall operate a Clinical Quality Management Program (CQMP) which results in demonstrable quality improvement of the health care provided to beneficiaries and of the processes and services that will be delivered. The contractor shall describe its quality improvement plan including its planned quality improvement initiatives, its planned research and/or clinical quality studies, and its planned patient safety/quality issue initiatives. The contractor shall describe how it will develop and implement policies and procedures to identify potential quality issues, resolve identified problems, and provide ongoing monitoring of the care and treatment of beneficiaries. The plan shall address how the contractor will monitor and report potential quality indicators (POIs) in accordance with the TOM, Chapter 7, Section 4. (b)(4)

(b)(4)

C-7.4. ACTIVE DUTY DENTAL CARE

C-7.4.1. The Contractor shall provide routine, urgent, and emergent dental care services to ADSMs who are enrolled in TOP Prime Remote, except for ADSMs in the

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U.S. territories of Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands (ADSMs in U.S. territories receive their dental care through Dental Treatment Facilities and/or the Active Duty Dental Program (ADDP) contract). Additionally, emergent or urgent dental care shall be provided to ADSMs who are TDY/TAD, deployed, deployed on liberty, or in an authorized leave status in a remote overseas location.

C-7.4.2. The Contractor shall serve as the dental network manager for TOP Prime Remote-enrolled ADSMs. These services shall include cashless, claimless access to a network of dental providers. The network of dental providers shall consist of dentists who have been evaluated and determined to meet generally accepted international hygiene and clinical practice standards. The Contractor shall inform the Government of locations where adequate numbers of qualified dental providers are not available through normal identification, credentialing and evaluations. All records pertaining to dental provider network development and credentialing shall be made available to the Government upon request.

C-7.4.3. The Contractor shall not authorize non-emergent active duty dental care over \$500/episode or \$1500/year without TRICARE Area Office coordination and approval. The Contractor shall ensure that the following documentation is provided to the TRICARE Area Office for pre-authorization review: Radiographs and diagnosis, treatment plan, estimated time required for care, probable cost, and projected length of tour of duty at the patient's present duty station.

C-7.4.4. The Contractor shall forward all orthodontic service requests for ADSMs to the responsible TRICARE Area Office for direction, regardless of the estimated cost of services.

C-7.4.5. Requests for ADSM dental specialty care from network providers shall be forwarded to the Contractor's Call Center(s) to determine appropriateness in consultation with the Government per TOM, Chapter 24, Section 10.

C-7.4.6. At the discretion of the Contractor, ADSM dental emergencies that cannot be adequately addressed may be treated as medical cases and shall interface with the medical management program. For example, if an ADSM resides in an area without a dental provider, they will be referred to a local medical provider for pain management pending travel (in coordination with the responsible TRICARE Area Office) to an area with a qualified dentist.

C-7.5. TAO AND MTF COORDINATION. The Contractor shall collaborate with the TAO Directors and MTF Commanders to ensure the most efficient mix of health care delivery between the MHS and the Contractor's system within the area. Collaboration includes, but is not limited to, MTF right of first refusal for referrals for all or designated specialty care, including ancillary services and coordinated preventive health care. Specific MTF coordination issues shall be addressed in the MTF Memorandum of Understanding (MOU). A separate MOU (drafted by the Contractor) shall be developed between each TAO Director and the Contractor. All MOUs shall be in writing and must be approved by the Contracting Officer, the MTF Commander (for MTF MOUs), the TAO Director (for TAO MOUs), and the TOP Regional Director. The Contractor shall initiate discussions related to MOUs and prepare the collaborative agreements. (See the TRICARE Operations Manual, Chapter 15).

C-7.6. ENROLLMENT

C-7.6.1. The Contractor shall perform all enrollments, re-enrollments, disenrollments, and enrollment transfers; clear enrollment discrepancies; and assign or change Primary Care Managers (PCMs) in accordance with the provisions of the TOM and the TSM. This includes enrollment activities associated with TOP Prime, TOP Prime Remote, TRICARE Plus, and TRICARE Reserve Select, and

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disenrollment actions associated with non-command sponsored ADFMs, retirees, and retiree family members who move from the United States to an overseas location.

C-7.6.2. The Contractor shall use the TRICARE Enrollment and Disenrollment forms, Attachments J-5 and J-6. The Contractor shall reproduce the forms as necessary to ensure ready availability to all potential enrollees and individuals requesting disenrollment.

C-7.6.3. The Contractor shall ensure that enrollment during transition phase-in and transfers of enrollment are accomplished in a manner that ensures uninterrupted coverage for TOP enrollees. During transition, the incoming Contractor shall enroll all MTF-enrolled ADSMs and command-sponsored ADFMs to TOP Prime. This includes TRICARE Puerto Rico Contract (TPRC) enrollees who are currently enrolled to Rodriguez Army Health Clinic (Fort Buchanan), USCG Clinic San Juan, and USCG Clinic Borinquen. The incoming Contractor shall enroll all TRICARE Global Remote Overseas (TGRO) enrollees and all other (TPRC) enrollees to TOP Prime Remote. Beneficiary enrollment periods shall be maintained from the preceding Contractor.

C-7.6.4. The Contractor shall coordinate its activities to establish enrollment protocols to effect the optimum enrollment mix and numbers in the MTFs for beneficiaries living within MTF enrollment areas. The Contractor will follow MTF guidelines (established in the MOUs between the Contractor and the MTF Commanders) for assigning MTF PCMs. The Contractor will follow TAO Director guidelines (established in the MOUs between the Contractor and the TAO Directors) for assigning TOP Prime Remote PCMs.

C-7.7. BENEFICIARY AND PROVIDER SERVICES

C-7.7.1. The Contractor shall provide comprehensive, readily accessible customer services that include multiple, contemporary avenues of access (for example, e-mail, World Wide Web, telephone, and facsimile) for MHS beneficiaries and providers. Customer services shall be delivered in a manner that achieves the objectives of this contract without charge to beneficiaries or providers. The Contractor shall perform all customer service functions with knowledgeable, courteous, responsive staff.

C-7.7.2. The Contractor shall meet with and establish an MOU with the TMA Communications and Customer Service (C&CS) Directorate in accordance with the TOM, Chapter 11, Section 1. The MOU shall address all interface requirements necessary to effectively administer the program. The Contractor shall partner and collaborate with C&CS on the identification and development of marketing and education materials required to support the accomplishment of the Marketing and Education Plan submitted in accordance with the TOM, Chapter 11. The Contractor shall use the Government's national suite of TRICARE educational materials pertaining to specific aspects of the TRICARE benefit and programs. The Contractor shall use the Government's mandatory formats to ensure "one look and feel" of all educational material. The Contractor will produce TOP provider education material in accordance with the TOM, Chapters 11 and 24, which must be reviewed by the TAO Director and concurred upon by the Contracting Officer.

C-7.7.3. The Contractor shall provide on-site Contractor personnel to perform beneficiary enrollment, beneficiary marketing and education, and health care finder functions at all locations identified at Attachment J-9, Government-Furnished Space and Equipment/Enrollment and Marketing Workload. The Contractor may also be required to provide on-site enrollment support at Government-specified locations (other than the TRICARE Service Center) for arriving/deploying units in accordance with TOM, Chapter 24, Section 5. Where the space is insufficient to support all Contractor activities in the TRICARE Service Center or TRICARE Area Office, the Contractor shall establish those customer services not available on site in a manner that is convenient to

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beneficiaries and provides the highest possible service levels. The Contractor shall be able to provide enrollment, beneficiary marketing and education, and health care finder functions during periods when access to the TRICARE Service Center or the TRICARE Area Office physical space is terminated or limited as a result of weather, war, security, or MTF/Installation Commander's decision.

C-7.7.4. The Contractor shall establish telephone Call Center service which complies with the requirements of TOM, Chapter 11, Section 7 and TOM, Chapter 24, Section 11. Call Center service (b)(4)

(b)(4) to provide worldwide-accessible telephone service for all MHS beneficiaries (regardless of actual enrollment location or permanent residence address) seeking eligibility determinations, program information, care authorization, and/or assistance in locating a host nation provider. The Contractor shall provide telephone claims service through their Call Center(s) or another location; (b)(4)

(b)(4) Call Center(s) may be physically located anywhere in the world as long as the required services can be provided in an efficient and effective manner. Call Center and telephone claims service shall be available without long distance telephone charges, regardless of whether the caller is located in the United States or overseas. Call Center personnel shall be able to enter authorizations for TOP Prime Remote enrollees; for ADSMs who require urgent care while TDY/TAD, deployed, deployed on liberty, or in an authorized leave status in a remote overseas location; and for beneficiaries in the 50 United States and the District of Columbia (other than USFHP or CHCBP enrollees) who require urgent care while traveling or visiting an overseas location. Emergency care never requires prior authorization; however, Call Center personnel shall assist all MHS beneficiaries as appropriate during a medical emergency. This includes, but is not limited to, providing information on local emergency care services (to include mental health services) and arranging or facilitating emergency medical evacuation when medically necessary and appropriate. Call Center(s) must have appropriate clinical oversight; licensed nursing staff (LPN, RN) with physician backup and specialized algorithms must be used for all care authorizations if physician staff does not answer the telephone calls.

C-7.7.5. The Contractor shall provide customer service support equal to twenty person-hours per month for each MTF listed in Attachment J-2, to be used at the discretion of and for the purpose specified by each MTF Commander. Examples of possible uses of this time include in-processing briefings/enrollments, TRICARE briefings, and specialty briefings on specific components of TRICARE or focused to a specific subset of TRICARE beneficiaries. This is in addition to the requirements for briefings and attendance at meetings specified in the TOM, Chapter 11. The Contractor shall also provide customer service support equal to twenty person-hours per month to be used at the discretion of and for the purpose specified by each TAO Director. The twenty person-hours for each MTF Commander and each TAO Director may be used at various locations and outside normal business hours. Unused hours from one month will not be carried over to subsequent months.

C-7.7.6. The Contractor shall conduct quarterly beneficiary and provider satisfaction surveys (using Government-provided survey instruments) to determine the satisfaction of enrolled beneficiaries and providers in using the Contractor's services. The survey shall measure customer satisfaction with regards to the following: (1) access to primary care providers; (2) access to specialty care providers; (3) ability to contact the Call Center; (4) quality of providers; (5) assistance received from the Call Center, and other factors that may be identified by the Government. Specifically, the Contractor shall conduct (b)(4) beneficiary surveys (as required by TOM Chapter 24, Section 11) based on a random sampling of claims from beneficiaries who have received services from host nation providers in the preceding (b)(4) months. The contractor may

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use their best business practices in selecting the actual format for conducting the surveys (e.g., paper, electronic, telephone, etc.). The survey instrument will be provided by the Government and will consist of approximately 10 closed-ended questions with a rating scale from 1 (completely satisfied) to 7 (completely dissatisfied). The contractor shall obtain 100 completed beneficiary surveys per TAO region on a (b)(4) basis. A similar process will be followed for host nation provider surveys; using a Government-provided survey instrument, the contractor shall randomly survey host nation providers who have rendered care to a TRICARE beneficiary in the preceding (b)(4) months. The contractor shall obtain 50 completed provider surveys per TAO region on a quarterly basis. The Government will provide the survey instruments to the successful offeror prior to the start of health care delivery. The Contractor shall submit their plan for conducting these surveys for Government review no later than 60 calendar days prior to the start of health care delivery, and annually thereafter no later than 60 calendar days prior to the start of each option period. Within 120 calendar days of submission of the plan to the Government; the Contractor shall implement the plan and provide summary reports of survey findings, unless specifically informed by the Contracting Officer that the plan is not adequate for implementation.

C-7.7.7.

(b)(4)

(b)(4)

C-7.7.8.

(b)(4)

(b)(4)

C-7.8. CLAIMS PROCESSING

C-7.8.1. The Contractor shall establish, maintain, and monitor an automated information system to ensure that TRICARE claims (including adjustments) are processed in an accurate and timely manner, and meet the functional system requirements as set forth in the technical requirements, the TOM, Chapters 8 and 24, and the TSM. The claims processing system shall be a single database and shall be HIPAA compliant.

C-7.8.2. The Contractor shall ensure that TRICARE claims (including adjustments) are timely and accurately adjudicated for all care provided to beneficiaries in accordance with the timeliness and quality standards of the TOM, Chapter 24, Section 9.

C-7.8.3. The Contractor shall accept paper claim forms in accordance with the TOM, Chapter 8. Standardized electronic transactions and code sets as required by the Administrative Simplification section of the Health Insurance Portability and Accountability Act (HIPAA) shall be accepted.

C-7.8.4. The Contractor shall, as one means of electronic claims submission, establish and operate a system for two-way, real-time interactive Internet Based

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Claims Processing (IBCP) by providing web-based connectivity to the claims/encounter processing system for both institutional and non-institutional claims processing. This IBCP system shall provide immediate eligibility verification by connectivity to DEERS and provide current deductible, catastrophic cap, and cost share/co-payment information to the provider online by connectivity to the DEERS catastrophic loss protection function and connectivity to the authorization system. The IBCP system shall comply with applicable DoD standards for security, to include DoD Information Assurance Certification and Accreditation Process (DIACAP) and encryption requirements. The Contractor shall regularly update the IBCP system to utilize newer encryption security protocols. The IBCP must be available for benchmark testing (see the TOM, Chapter 1, Section 7).

C-7.8.5. The Contractor's claims processing system shall interface with and accurately determine eligibility and enrollment status based on the Defense Enrollment Eligibility Reporting System (DEERS) in accordance with the TSM.

C-7.8.6. The Contractor's claims processing system shall accurately process claims in accordance with the TRICARE benefit and reimbursement policy as delineated in 32 CFR Part 199.4 and 199.5, the TPM, the TRM, and the TOM. The Contractor's claims processing system shall correctly apply deductible, co-pay/coinsurance, cost shares, catastrophic cap, and POS provisions in accordance with the TRICARE benefit policy as delineated in 32 CFR 199.4 and 199.5, 199.17 and 199.18, the TPM, and the TRM. This shall include the correct application of deductible, co-pay/coinsurance, cost shares, catastrophic cap, and Point of Service (POS) provisions. The Contractor's claims processing system shall accurately coordinate benefits with other health insurances to which the beneficiary is entitled as required by 32 CFR 199.8, the TPM, and the TRM.

C-7.8.7. Claims requiring additional information shall be returned or developed for the missing information. The Contractor shall ensure that all required information is requested with the initial return or development action and that no claim is returned/developed for information that could have been obtained internally or from DEERS. The Contractor shall ensure that an adequate audit trail is maintained for all returned or denied claims.

C-7.8.8. The Contractor shall ensure that non-network claims received more than 12 months after the date of service (or discharge) are denied unless the requirements contained in 32 CFR 199.7 are met, or unless an exception to the claims filing deadline has been granted in accordance with the TOM, Chapter 1, Section 2. Timely filing requirements for network providers shall be governed by the network provider agreement, but shall not exceed 12 months from date of service (or discharge) except as specified above.

C-7.8.9. The Contractor shall provide pharmaceutical services, including facilitation of claims processing for pharmaceuticals provided in conjunction with inpatient or outpatient care. Claims for pharmaceuticals paid under this contract shall meet US equivalent or international standards. Medications that are considered over-the-counter by U.S. standards are not authorized for reimbursement.

C-7.8.10. If prescribed pharmaceuticals, not to include immunizations, are not available locally and are refrigerated items not covered for overseas residents under the TRICARE Mail Order Pharmacy program, the Contractor is authorized to ship pharmaceuticals to TOP-enrolled beneficiaries. Shipping costs shall be included in the drug claim.

C-7.8.11. If immunizations are not available through an embassy clinic or a local provider, the Contractor is authorized to ship immunizations to a clinic or provider for TOP-enrolled beneficiaries. Shipping costs shall be included in the claim. Immunizations required for foreign travel are not covered for family

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members who are traveling outside the overseas location of enrollment, unless such travel is being performed under orders issued by a Uniformed Service and is a result of the AD member's assignment to another country that is covered under this contract.

C-7.8.12. The Contractor shall accurately reimburse network and non-network provider claims in accordance with applicable statutory (US Code, Chapter 55, Title 10) and regulatory provisions (32 CFR 199.14) and with the TRM and the TOM. Payment to host nation providers shall be the lesser of billed charges, the negotiated rate, or the TMA-established reimbursement rate.

C-7.8.13. The Government anticipates the implementation of Government-directed foreign fee schedules in the Philippines and Panama prior to the start work date of this contract. Specific implementing instructions will be published in the TRICARE Manuals. Additional countries may be added prior to the start work date of this contract, or during the life of this contract. Government-directed foreign fee schedules are determined by multiplying a specific factor against any value listed on the current national CMAC file to produce the maximum amount to be reimbursed for a service or procedure in that country. For example, a procedure code that is listed on the national CMAC file at \$10.00 would be reimbursed at \$5.20 in the Philippines and \$7.00 in Panama (during the first year following implementation of the foreign fee schedules). Government-directed foreign fee schedules are applicable to all inpatient and outpatient care and all beneficiary categories, unless a different process has been authorized by the Government (see TOM Chapter 24, Section 9). The Contractor may, at its discretion, negotiate discounts with network providers that result in reimbursement rates that are lower than the Government-directed foreign fee schedule rates; however, reimbursement to any provider (network or non-network) cannot exceed the Government-directed foreign fee schedule rate in that country except when a different rate is authorized in accordance with TRM, Chapter 1, Section 34 and TOM, Chapter 24, Section 9. The anticipated factors (subject to change by the Government) for the Philippines and Panama are as follows:

Philippines	0.229
Panama	0.60

C-7.8.14. The Contractor shall provide each beneficiary and provider with an Explanation of Benefits (EOB) that meets the requirements of the TOM, Chapters 8 and 24. The EOB must clearly describe the action taken on the claim or claims and provide information regarding appeal rights, to include the address and instructions for filing an appeal. The EOB must also provide information on the deductible and catastrophic cap status following processing, as well as sufficient information to allow a beneficiary to file a claim with a supplemental insurance carrier. Providers shall receive EOBs at their service address for all care rendered even if the provider uses a Third Party Administrator. The Contractor shall send a duplicate EOB, without charge to the beneficiary and within 5 calendar days of receiving a request (written, verbal, or electronic) for an EOB from a beneficiary, regardless of their status.

C-7.8.15. The Contractor may issue monthly summary EOBs to beneficiaries on claims when there is no beneficiary liability. The processing date of the oldest claim for the summary EOB shall not be greater than 31 calendar days.

C-7.8.16. The Contractor shall accurately capture and report TRICARE Encounter Data (TED) related to claims adjudication in accordance with the provisions of the TSM and shall ensure the standards contained in this contract are achieved. All TED records shall comply with the information management requirements of this contract and shall be reported in compliance with the standards in the TOM, Chapter 9.

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C-7.8.17. The Contractor shall submit information on all providers authorized by the Contractor, to the TMA centralized TRICARE Encounter Provider Record system in accordance with the provisions of the TSM.

C-7.8.18. The Contractor shall ensure that appeal requests are properly handled and timely pursued as defined in 32 CFR 199.10 following the instructions in the TRICARE Operations Manual, Chapters 12 and 24, and the standards in the TRICARE Operations Manual, Chapter 1, Section 3.

C-7.8.19. During the life of this contract, the Government may change the reimbursement process for MTF-referred supplemental health care. These claims are currently managed by the MTFs and reimbursed through the Defense Finance and Accounting Service (DFAS); however, the Government may direct that these claims be processed and paid under this contract. If implemented, the Contractor shall submit a cost estimate and comprehensive implementation plan to the Contracting Officer for review and approval prior to implementation.

C-7.9. DATA ACCESS AND SECURITY

C-7.9.1. The Contractor shall provide to authorized Government personnel (as determined by the Contracting Officer) unlimited off-site electronic access to ALL data maintained by the Contractor as outlined in C-7.9.2. Minimum access shall include two authorizations at each MTF, two authorizations at each Surgeon General's Office, two authorizations at the TOP Regional Director's Office, two authorizations at each TAO, two authorizations at Health Affairs, two authorizations at TMA-Northern Virginia, and two authorizations at TMA-Aurora. The Contractor shall make available an additional 15 authorizations to be assigned at the discretion of the Government. The Contractor shall also provide read-only access to claims and enrollment data to the Department of Defense (DoD) TRICARE Information Center, designated TMA sites and personnel, and all overseas Health Benefits Advisors (HBAs), Beneficiary Counseling and Assistance Coordinators (BCACs), and Debt Collection Assistance Officers (DCAOs). The Contractor shall provide training and ongoing customer support for data access. Web-based training is acceptable; however, it must be provided on an ongoing basis and must be updated as systems changes occur.

C-7.9.2. The Contractor shall provide access to all data at the beneficiary, non-institutional, and institutional level to Government personnel identified in C-7.9.1. This data includes, but is not limited to, data concerning the provider network, enrollment information, referrals, authorizations, claims processing, program administration, beneficiary and provider satisfaction and services, and incurred cost data. All data must be current, accurate, complete and accessible in real time. Complete information includes all data pertaining to the execution of TOP benefits. Search and drill down capabilities must be built into systems and must be user friendly. At a minimum, the data shall be available for queries by region, country, city, DMIS, and MTF enrollment area, and beneficiary category. (b)(4)

(b)(4) Ad hoc reports prepared by the Contractor must satisfy the user's requirements within the time frames agreed upon by the Government and the Contractor. The data access interface will be mutually agreed upon by the Contractor and each TRICARE Area Office, and must be available at the start of health care delivery.

C-7.9.3. The contractor shall provide information management and information technology support as needed to accomplish the stated functional and operational requirement of the TRICARE program and in accordance with the TSM and the MHS Enterprise Architecture (See <http://www.ha.osd.mil/mhscio/ea> reference docs.htm).

C-7.9.4. The contractor shall enter into a Data Use Agreement (DUA) for data obtained from DoD Systems and applications and comply with DoD 6025.18-R, DoD H94002-10-D-0001

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Health Information Privacy Regulation, HIPAA Privacy Rule, and DoD 5400.11-R DoD Privacy Program, by submitting a DUA to the Privacy Office annually or until their contract is no longer in effect as required in the TSM and the TOM.

C-7.9.5. The Contractor shall ensure its subcontractors and/or their agents who require the use of or access to individually identifiable information or protected health information under the provisions of this contract comply with DoD regulations and the TRICARE Systems Manual.

C-7.9.6. The Contractor shall develop a continuous data quality management program for Contractor data.

C-7.9.7. Personnel Security. The Contractor shall coordinate with the Government to ensure compliance with the Personnel Security Program of DoD 5200.2-R and the TSM, Chapter 1. The Contractor shall initiate and document all activities necessary to ensure compliance with the Personnel Security Program of DoD 5200.2-R and the TSM, Chapter 1. The Contractor shall also ensure all personnel, to include subcontractors and/or their agents, comply with all system access requirements including initial and refresher training at intervals designated by the Government.

C-7.9.8. System Security. The Contractor shall acquire, develop and maintain the DoD Information Assurance Certification and Accreditation Process (DIACAP) documentation to ensure both initial and continued DIACAP Certification and Accreditation (C&A) for all Contractor/subcontractor systems/networks processing or accessing Government sensitive information (SI) as required by TSM, Chapter 1. The Contractor shall cooperate with and assist the Government's (MHS) DIACAP C&A Team during all phases of the C&A process by providing documentation in accordance with the MHS DIACAP C&A team schedule. The Contractor shall also put in place processes that meet the requirements of the TSM, Chapter 1 to ensure at least a Mission Assurance Category (MAC) III Sensitive level of security protection for systems/networks that process MHS SI under this contract. DIACAP certification generally takes 6 to 9 months to achieve and the Contractor shall plan the certification activity that results, at a minimum, in an Interim Authority To Operate (IATO) prior to accessing DoD data or interconnectivity with the Government systems and testing. (See DoD 8500.2 (Information Assurance Implementation) and DoD 5200.40.)

C-7.9.9. The Contractor shall comply with DoD Information Assurance (DoD Directive 8500.1), MAC III, Sensitive Requirements found in DoD Information Assurance Implementation (DoD Instruction 8500.2), Privacy Act Program Requirements (DoD 5400.11), Personnel Security Program (DoD 5200.2-R) and the MHS AIS Security Policy Manual. The Contractor shall also comply with OMB M-06-16, Protection of Sensitive Agency Information. The Contractor shall comply with DoD Minimum Security Requirements as outlined in the TSM, Chapter 1.

C-7.9.10. The Contractor shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, specifically the administrative simplification provisions of the law and the associated rules and regulations published by the Secretary, Health and Human Services (HHS), the DoD Health Information Privacy Regulation (DoD 6025.18-R) the Health Insurance Portability and Accountability Act Security Compliance Memorandum (HA Policy 06-010), the Security Standards for the Protection of Electronic Protected Health Information and the requirements in the TOM, Chapter 19, and the TSM, Chapter 1.

C-7.9.11. The Contractor shall ensure that all electronic transactions comply with HIPAA rules and regulations and TMA requirements in the TSM, Chapter 1 and the TOM, Chapter 19.

C-7.9.11. All portable computer systems used by the Contractor (including subcontractors and agents) to store, process, or otherwise use and manipulate

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Personally Identifiable Information (PII) and/or Protected Health Information (PHI) shall be equipped with an active theft recovery system that provides information to law enforcement for the recovery of lost, stolen and missing computers.

C-7.9.12. Pursuant to FAR Part 24, the requirements of the Privacy Act (5 U.S.C. 552a) and the Department of Defense Privacy Program (DoD 5400.11-R) are applicable to this contract and the systems of records operated and maintained by the Contractor on behalf of the TRICARE Management Activity (TMA). These systems of records are found at 65 Federal Register 30966 (Health Benefits Authorization Files, Medical/Dental Care and Claims Inquiry Files, Medical/Dental Claim History Files), 60 FR 43775 (USTF Managed Care System), 69 Federal Register 50171 and 71 Federal Register 16127 (Military Health Information System), and 64 FR 22837 (Health Affairs Survey Data Base). The records system operated and maintained by TMA Contractors are records systems operated and maintained by a DoD Component (TMA). (See TRICARE Operations Manual 6010.56-M, Chapter 1, Section 5; Chapter 2, Section 1; and Chapter 2, Section 2.)

C-7.10. MANAGEMENT

C-7.10.1. The Contractor shall comply with all management standards in the TOM, Chapter 1, Section 4.

C-7.10.2. **QUALITY MANAGEMENT / QUALITY IMPROVEMENT.** The Contractor shall establish and continuously operate an internal quality management/quality improvement (QM/QI) program that will provide the Contractor's management with effective and efficient means of identifying and correcting problems throughout the duration of the contract. The Contractor shall submit a QM/QI plan to the Contracting Officer within 30 calendar days of contract award. Subsequently, the Contractor shall submit an updated QM/QI plan within 10 calendar days of making any changes to the existing plan. The Contractor shall provide a quarterly briefing (in person or via video teleconference, as proposed by the Contractor) to the TRICARE Overseas Program Regional Director and TMA staff on the Contractor's ongoing internal quality management/quality improvement program. A copy of the documents describing the internal quality management/quality improvement program shall be provided to the Contracting Officer in accordance with Section F-7.1.7. A report listing the problems identified by the Contractor's internal quality management/quality improvement program and the corrective actions planned/initiated shall be provided to the Contracting Officer in accordance with Section F-7.1.9. At a minimum, the Contractor's QM/QI program shall include the following:

- Quality Practices
- Claims Processing/Claims Review
- Internal Controls
- Utilization Review, Quality of Care, and Utilization Management Processes
- Host Nation Provider Credentialing, Re-Credentialing, and Certification Activities
- Beneficiary and Provider Communications and Satisfaction Monitoring
- Appeals and Grievances Procedures.
- Access to Care Monitoring Procedures.

C-7.10.3. The Contractor shall implement processes and procedures that ensure full compliance with the most current version of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry's Consumer Bill of Rights and Responsibilities (see <http://www.hcqualitycommission.gov>).

C-7.10.4. All beneficiary records used in any way by the Contractor must be protected as required by the Freedom of Information Act, the Privacy Act of H94002-10-D-0001

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1974, the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act, and the Health Insurance Portability and Accountability Act of 1996. The Contractor shall comply with the HHS Privacy Regulation Training and Education requirements of the TOM, Chapter 19, Section 3. Beneficiary records must be protected, in terms of privacy and security, during use, transmission, storage, destruction, and handling. All beneficiary records used during the execution of this contract must be maintained, transferred, stored, and destroyed in accordance with the TOM, Chapter 2. Beneficiary records cannot be used for any purpose not related to the contract.

C-7.10.5. The Contractor shall develop a process to ensure that the Government and the Contractor's customer service personnel have access to all data associated with MHS beneficiaries at program start-up and through the phase-out of the contract. A process will be established for transfer of this data and will be in place and operational prior to the end of the contract.

C-7.10.6. The Contractor shall ensure that all Contractor personnel working in an MTF meet the MTF-specific requirements of the facility in which they will be working and comply with all local Employee Health Program (EHP) and Federal Occupational Safety and Health Act (OSHA) Blood Borne Pathogens (BBP) Program requirements.

C-7.10.7. The Contractor shall develop and implement, in conjunction with the TOP Regional Director and the TRICARE Area Offices, a contingency program designed to ensure that health care services are continuously available to TRICARE eligible beneficiaries as the MTFs respond to war, operations other than war, deployments, training, contingencies, special operations, and natural disasters. The Contractor's contingency program shall also address the Contractor's process for ensuring continuity of operations (including the timeline for responding to contingencies) during any contingency that may impact operations at the Contractor's call centers, or other Contractor locations that are not co-located with an MTF. The draft contingency program shall be provided to the TOP Regional Director, the TAO Directors, and the Contracting Officer 120 calendar days prior to the start of health care delivery. The final version of the contingency program shall be provided to the Government no later than 60 calendar days prior to the start of health care delivery, and shall be updated annually.

C-7.10.8. The Contractor shall implement the contingency program at any or all locations within forty-eight (48) hours of being notified by the TOP Regional Director or TAO Director that a contingency exists.

C-7.10.9. At midnight Pacific Time on the last day of health care delivery under this contract, the outgoing Contractor shall assign rights to the toll-free telephone number(s) serving the overseas regions to the incoming Contractor.

C-7.11. PROGRAM INTEGRITY.

C-7.11.1. The Contractor shall ensure that instances of fraud and abuse, as defined in 32 CFR 199.9, are minimized, promptly identified and aggressively pursued and resolved.

C-7.11.2. In accordance with 32 CFR 199.9 and the TRICARE Operations Manual, Chapter 13, the Contractor shall ensure appropriate identification and referral of potential cases of fraud and/or abuse, and provide support in the Government's investigation and resolution of potential fraud and/or abuse cases, including provider exclusions, suspensions, termination, and reinstatements.

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C-7.11.3. In addition to the references cited in C-7.11.2 above, the Contractor shall comply with the provisions of the TRICARE Operations Manual, Chapter 24 as they relate to anti-fraud activities in specific overseas locations.

C-7.12. TRANSITIONS

C-7.12.1. Upon award of the contract, the Contractor shall comply with the start-up and transitional requirements of the TRICARE Operations Manual, Chapter 1, Section 7.

C-7.12.2. Residual claims for overseas care shall be processed by the incoming TOP Contractor. One hundred twenty (120) calendar days following the end of any Managed Care Support Contractor's health care delivery period, the incoming TOP Contractor shall process all claims received for care outside the fifty United States and the District of Columbia that occurred during the outgoing Managed Care Support Contractor's health care delivery. This process applies to all residual claims except for USFHP and CHCBP enrollees.

C-7.12.3. At the conclusion of this contract, the Contractor shall meet with and provide to the successor Contractor and/or the Government the information necessary to facilitate a seamless transition in accordance with the TRICARE Operations Manual, Chapter 1, and any additional information agreed to by the parties.

C-7.12.4. The Contractor shall provide ongoing collaboration with the Government to ensure that the appropriate Government personnel, as identified in the Transition Plan, are kept informed of start up and transition progress. The frequency, type, and nature of communication shall be based on the task and involvement of the Government. Any commonly used form of business communication (e.g., telephonic, e-mail) is acceptable to the Government unless otherwise specified in the Transition Plan.

C-7.12.5. The Contractor shall ensure that enrollment on transition phase-in and transfers of enrollment are accomplished in a way that allows for uninterrupted coverage for the TRICARE Overseas Prime enrollee and minimal disruption to the MTFs. During transition, the incoming Contractor shall make every effort to retain existing network providers and to enroll all TRICARE Overseas Prime beneficiaries to their currently assigned Primary Care Manager.

C-7.12.6. The specific incentives associated with this contract (to include positive and negative incentives, performance guarantees, and award fees) are not applicable during contract transition.

C-7.13. INTERFACES

C-7.13.1. The Contractor shall provide a method of interface between the Contractor, MTFs, TAOs, and the Military Medical Support Office (MMSO) for eligibility verification and care authorization/approval for claims payments of medical care from civilian sources for Guard/Reserve Component members on active duty for 30 days or less according to the TRICARE Operations Manual, Chapter 24.

C-7.13.2. The Contractor shall initiate discussions related to collaboration with the Regional Director and MTF Commanders to ensure the most efficient mix of health care delivery between the MHS and host nation providers. Collaboration includes, but is not limited to, right of first refusal for referrals for all or designated specialty care, including ancillary services and coordinated preventive health care. A Memorandum of Understanding (drafted by the Contractor) between each TAO Director, MTF Commander, and the Contractor shall be in writing and must be approved by the Contracting Officer and the TOP Regional Director at least 60 calendar days prior to the start of health care delivery.

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C-7.13.3. When traveling to foreign countries to perform the requirements of this contract, the Contractor shall reference the Foreign Clearance Guide for specific country and theater information to ensure that the appropriate Government personnel are aware of the Contractor personnel entering that country. The guide can be found at <https://www.fcg.pentagon.mil>. The web site will require the Contractor to complete training modules and seek country clearance approval from the respective Unified Combatant Commands. If problems are encountered accessing this website, the Contractor shall notify HQ USAF/A3SPI-ISP, International Sovereignty Policy office at 703-614-0225 or by email at www.fcg@pentagon.af.mil.

(End of Section)

SECTION D
PACKAGING AND MARKING

D.1

D-1.1. Preservation, packaging, and marking for all items delivered hereunder shall be in accordance with Federal and State laws for shipment. The reports and other products to be furnished hereunder shall be adequately packaged and packed to ensure safe delivery at destination. All products must be clearly marked to identify the contract number, contents, the sender, and the individual/office to which they are being sent. Extra care shall be taken in packaging electronic media to protect against damage and to ensure that the electronic media does not become separated from the routing markings. All reports and other products to be furnished are to be shipped via a method that provides for acknowledgment of receipt. The Contractor shall retain such receipts. Shipments containing electronic media shall be marked as such and shall include the statement "Do Not X-Ray."

D-1.2. All beneficiary records used in any way by the Contractor must be protected as required by the Freedom of Information Act, the Privacy Act of 1974, the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Beneficiary records must be protected, in terms of privacy and security during use, transmission, storage, destruction, and handling.

D-1.3. The Contractor shall make use of commercial best practices in the packaging and shipment of packages, unless otherwise stated in this statement of work.

D-1.4. **METHOD OF DELIVERY.** Unless otherwise specified, all deliverables shall be made to TMA in electronic format unless otherwise directed by the Contracting Officer.

D-1.5. **SHIPPING.** The Contractor shall use the U.S. Postal Service standard delivery for delivery of materials, equipment, or required hardcopy documents. The TMA Contracting Officer Representative (COR) must approve all exceptions to this requirement.

(End of Section)

SECTION E
INSPECTION AND ACCEPTANCE

E-1. 52.246-4 INSPECTION OF SERVICES - FIXED PRICE (AUG 1996)
(Reference 46.304)

E-2. 52.246-5 INSPECTION OF SERVICES - COST REIMBURSEMENT (APR 1984)
(Reference 46.305)

E-3. 252.247-7000 HARDSHIP CONDITIONS (AUG 2000)
(Reference 247.270-6(a))

E-4. INSPECTION AND ACCEPTANCE

E-4.1. The final acceptance authority for the Government shall be:

Office of the Assistant Secretary of Defense for Health Affairs
TRICARE Management Activity
TRICARE Overseas Program Branch
5111 Leesburg Pike, Skyline 5, Suite 810
Falls Church, VA 22041-3206
(703) 681-0039

Or as directed by the PCO

(End of Section)

**SECTION F
DELIVERIES OR PERFORMANCE**

F-1. 52.242-15 STOP-WORK ORDER (AUG 1989), ALTERNATE I (APR 1984)
(Reference 42.1305(b) (1) and (2))

F-2. PERIOD OF PERFORMANCE

F-2.1. Base Period: Date of Award (November 1, 2009) through August 31, 2010
(ten month transition)

F-2.2. Option Periods 1 through 5 (if exercised) will be:

Option Period 1	September 1, 2010 through August 31, 2011
Option Period 2	September 1, 2011 through August 31, 2012
Option Period 3	September 1, 2012 through August 31, 2013
Option Period 4	September 1, 2013 through August 31, 2014
Option Period 5	September 1, 2014 through August 31, 2015

F-2.3. CONTRACT TRANSITION

The transition period is 10 months in duration.

F-3. GEOGRAPHIC AREA OF COVERAGE

The contract covers health care support services outside the 50 United States and the District of Columbia. The U.S. territories of Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands are included in the health care coverage of this contract. The contract also covers Active Duty Service Member (ADSM) dental care in remote locations outside the 50 United States and the District of Columbia, not including U.S. territories.

F-4. PLACE OF DELIVERY AND PROCEDURES

F-4.1. The Contractor shall make delivery under this contract to the location(s) set forth in each individual Delivery Order issued.

F-4.2. All certified and overnight mail for TRICARE Management Activity (TMA) is to be delivered to: TRICARE Management Activity, 16401 E. Centretch Parkway, Aurora, CO 80011-9066. TMA Normal Delivery Hours are 7:30 a.m. to 4:00 p.m. (local time), Monday through Friday, excluding Federal Holidays.

F-4.3. All mail directed to the Contracting Officer (CO) shall be addressed to the TRICARE Management Activity, Attention: TOP Contracting Officer, 16401 E. Centretch Parkway, Aurora, CO 80011-9066. TMA Normal Delivery Hours are 7:30 a.m. to 4:00 p.m. (local time), Monday through Friday, excluding Federal Holidays.

F-4.4. All mail directed to the Contracting Officer Representative (COR) shall be addressed to the TRICARE Management Activity, Attention: TRICARE Overseas Program Office, Skyline 5, Suite 810, 5111 Leesburg Pike, Falls Church, VA 22041-3206. TMA Normal Delivery Hours are 7:30 a.m. to 4:00 p.m. (local time), Monday through Friday, excluding Federal Holidays.

F-5. NOTICE REGARDING LATE DELIVERY

F-5.1. In the event the Contractor anticipates difficulty in complying with the delivery order schedule, the Contractor shall immediately notify the Contracting Officer (CO) or the Contracting Officer Representative (COR), in writing, giving pertinent details, including the date by which it expects to make delivery; provided however, that this notification shall be informational only in character and that receipt thereof, shall not be construed as a waiver by the

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SECTION F
DELIVERIES OR PERFORMANCE

Government of any contract delivery schedule, or any rights or remedies provided by law or under this contract.

F-6. EXTENSIONS

F-6.1. Request for extensions initiated by the Contractor of due dates for deliverables under this contract shall be furnished to the CO such that the request is received on or before the 5th working day prior to the due date in question. Requests may be transmitted via electronic methods or telefax. Requests shall be in writing. Requests shall include a detailed explanation of the circumstances justifying the extension, the date by which delivery can occur, and the justification for that date. In reviewing a Request for Extension of Due Date, the CO shall consider whether there were circumstances beyond the foreseeable control of the Contractor and TMA that prevents timeliness. Failure to adequately manage workload shall not be an acceptable basis for an extension. The Contractor cannot assume an extension will be automatically granted.

F-7. REPORTS AND PLANS

Unless otherwise specified, Contractors shall electronically submit all deliverables (contract plans, reports, etc.) in a format approved by the Contracting Officer to include Microsoft Office Excel, Word, PDF, or other specified format. (Certain reports must be delivered in Microsoft Excel.) Unless otherwise specified, all deliverables shall be submitted to TMA via the E-commerce Extranet (<https://tma-ecomextranet.ha.osd.mil/logon/logon.cfm>). This system permits the Contractor to log on to a secure system and upload the required documents. The system is accessed via the Internet through a workstation browser. The application is "thin client" meaning that no software needs to be installed on the client workstation and no software is downloaded into the browser. Javascript and cookies need to be enabled in the browser to utilize the application. The application is best viewed at a resolution of 1024 X 768 pixels in an Internet Explorer browser. The system must be accessed using the Secure Socket Layer protocol (<https://>) and is protected by individually assigned username and password. Access to the Extranet must be requested using the E-commerce Extranet Access Form which will be provided by the Government. While files are being submitted over the Internet they are encrypted within the secure layer. When files are stored on the TRICARE server, they are renamed with a randomly generated name of varying length. Access to information is granted to users at the contract level. Information submitted by one Contractor will not be accessible to any other Contractor.

F-7.1. Reports: The Contractor shall provide all reports and plans that are required by the Contract Data Requirements List (CDRLs), DD Forms 1423, incorporated into the contract at attachment J-8. The Contractor is accountable for assuring that reports contain accurate and complete data. The Contractor shall prepare written procedures describing the source of information as well as the specific steps followed in the collection and preparation of data for each report. All reports must be supported with sufficient documentation and audit trails. The reports shall be titled as listed. The Contractor shall submit a negative report if there is no data to report.

(End of Section)

SECTION G
CONTRACT ADMINISTRATION DATA

G-1 252.204-7006 BILLING INSTRUCTIONS (OCT 2005)

When submitting a request for payment, the Contractor shall-

- (a) Identify the contract line item(s) on the payment request that reasonably reflect contract work performance; and
- (b) Separately identify a payment amount for each contract line item included in the payment request.

(End of Clause)

G-2 252.232-7003 ELECTRONIC SUBMISSION OF PAYMENT REQUESTS (MAR 2008)

- (a) "Definitions." As used in this clause--
 - (1) "Contract financing payment" and "invoice payment" have the meanings given in Section 32.001 of the Federal Acquisition Regulation.
 - (2) "Electronic form" means any automated system that transmits information electronically from the initiating system to all affected systems. Facsimile, e-mail, and scanned documents are not acceptable electronic forms for submission of payment requests. However, scanned documents are acceptable when they are part of a submission of a payment request made using Wide Area WorkFlow (WAWF) or another electronic form authorized by the Contracting Officer.
 - (3) "Payment request" means any request for contract financing payment or invoice payment submitted by the Contractor under this contract.
- (b) Except as provided in paragraph (c) of this clause, the Contractor shall submit payment requests and receiving reports using WAWF, in one of the following electronic formats that WAWF accepts: Electronic Data Interchange, Secure File Transfer Protocol, or World Wide Web input. Information regarding WAWF is available on the Internet at <https://wawf.eb.mil/>.
- (c) The Contractor may submit a payment request and receiving report using other than WAWF only when--
 - (1) The Contracting Officer authorizes use of another electronic form. With such an authorization, the Contractor and the Contracting Officer shall agree to a plan, which shall include a timeline, specifying when the Contractor will transfer to WAWF;
 - (2) DoD is unable to receive a payment request or provide acceptance in electronic form;
 - (3) The Contracting Officer administering the contract for payment has determined, in writing, that electronic submission would be unduly burdensome to the Contractor. In such cases, the Contractor shall include a copy of the Contracting Officer's determination with each request for payment; or
 - (4) DoD makes payment for commercial transportation services provided under a Government rate tender or a contract for transportation services using a DoD approved electronic third party payment system or other exempted vendor payment/invoicing system (e.g., PowerTrack, Transportation Financial Management System, and Cargo and Billing System).
- (d) The Contractor shall submit any non-electronic payment requests using the method or methods specified in Section G of the contract.
- (e) In addition to the requirements of this clause, the Contractor shall meet the requirements of the appropriate payment clauses in this contract when submitting payment requests.

(End of Clause)

G-3. CONTRACT ADMINISTRATION

G-3.1. The Procuring Contracting Officer (PCO) is responsible for the administration of this contract and is solely authorized to take action on behalf of the Government. Unless specified otherwise within this contract, the

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PCO is referred to as the Contracting Officer. The Contracting Officer for this contract is located at:

Office of the Assistant Secretary of Defense for Health Affairs
TRICARE Management Activity
Acquisition Management & Support
16401 East Centretex Parkway
Aurora, CO 80011-9066

G-3.2. Administrative Contracting Officer (ACO):
Defense Contract Management Agency (DCMA) ACO. The Contracting Officer will delegate a limited number of functions listed in FAR 42 to the DCMA ACO. The Contractor will be provided copies of all delegation letters.

DCMA Surface Communication and Support Systems Philadelphia
700 Robbins Avenue, Bldg. 4-A
P.O. Box 11427
Philadelphia, PA 19111-0427
Telephone:
FAX Phone:

G-3.3. Defense Contract Audit Agency (DCAA) will provide certain audit functions in support of the Contracting Officer and ACO.

DCAA Supervisory Auditor Healthcare CBBO Chesapeake Bay Branch Office
10025 Gov. Warfield Parkway, Suite 220
Columbia, MD 21044

G-3.4. Contracting Officer's Representative (COR)

The Contracting Officer will designate a Contracting Officer's Representative (COR) in writing, and provide a copy of the designation letter to the Contractor. The designation letter will delineate the scope of authority of the COR to act on behalf of the Contracting Officer. The COR has no authority to make any commitments or changes that affect any term or condition of the contract.

G-3.5. Contractor Points of Contact personnel

The names and addresses of the Contractor's primary and alternate point of contact (POC) for contract implementation and compliance are as follows:

Primary:	Alternate:
Sandra W. Johnson	Keith Deveney
Sr. Executive Vice President	Director, TRICARE Global Operations
Telephone: 215-942-8030	Telephone: 215-942-8031
FAX Phone: 215-354-2313	FAX Phone: 215-354-2361

G-3.6. Paying office:

Department of Defense
TRICARE Management Activity
ATTN: Contract Resource Management (CRM)
16401 E. Centretex Parkway
Aurora, CO 80011-9066

G-4. ORDERING ACTIVITY/PROCEDURES

SECTION G
CONTRACT ADMINISTRATION DATA

The following describes the ordering authority and procedures for CLINs 0001 - 0003 pertaining to Transition-in, 1001-5001 pertaining to Per Member Per Month (PMPM) Managed Care Fee, 1002-5002 Claims Processing, 1003-5003 Transient Care Management, 1004-5004 Translation Services, 1005-5005 Disease Management, 1006-5006 Award Fee, 1007-5007 Incentive Fee, 1009-5009 Contract Administration, and 1010-5010 Transition Out.

G-4.1. Ordering authority: Only the TMA Contracting Officer has authority to issue orders under the CLINs listed in G-4.

G-4.2. Ordering Procedures: All delivery orders will be issued on DD 1155, Order for Supplies or Services. Orders may be placed by facsimile transmission, mail, email, or courier.

G-5. OTHER INSTRUCTIONS TO PAYING OFFICE

G-5.1. The paying office will follow paying instructions included in any contract modification, including change order definitizations and performance incentive payment modifications.

G-5.2. Revisions to payment instructions may be made as circumstances require. This may be accomplished by correspondence between the contracting office and the paying office.

G-6. PMPM MANAGED CARE FEE - PRIME ENROLLED MEMBERS (CLINs 1001-5001)

G-6.1. For the purpose of this CLIN, counts of Managed Care Fee - Prime Enrolled Members under the PMPM includes all TOP Prime and TOP Prime Remote enrollees.

G-6.2. The Government will retrospectively unilaterally determine the number of TOP Prime and TOP Prime Remote enrollees on a monthly basis, based on the contractor's monthly enrollment report and information contained in the Defense Enrollment Eligibility Reporting System (DEERS).

G-7. INVOICE AND PAYMENT - NON-TEDS ADMINISTRATIVE CLINs

Unless otherwise stated, non-TEDs invoice and vouchers shall be submitted in accordance with G-2 above electronically. A proper invoice must include the elements identified at FAR 32.905.

G-7.1. Transition In (CLIN 0001): The Contractor may invoice for interim payment of 50% of the transition-in price upon the start of health care delivery. The Contractor may submit a final invoice (DD 250) for the balance following completion of all transition requirements.

G-7.2. DIACAP Certification (CLIN 0002): Submit invoice only after completion receipt of DIACAP Authority to Operate Certification.

G-7.3. PMPM (CLINs 1001-5001): Submit invoice no more frequently than monthly and only after completion of the given month for the number of enrollees determined by the Government per G-6.2.

G-7.5. Transient Care Management Fee (CLINs 1003-5003): Submit invoice no more frequently than monthly and only after completion of the given month. Supporting documentation shall include a list of all beneficiaries receiving care with name, address, SSNs, DOS, status, and date of service.

G-7.6. Translation Services (CLINs 1004-5004): Submit invoice no more frequently than monthly and only after completion of the given month.

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G-7.7. Disease Management (CLINs 1005-5005): Submit invoice no more frequently than monthly and only after completion of the given month. Supporting documentation shall include a list of all beneficiaries receiving care with name, address, SSNs, DOB, status, and date of service.

G-7.8. Semiannual Award Fee (CLINs 1006-5006): The Contractor shall invoice as instructed by the Contracting Officer following determination of any award fee.

G-7.9. Incentive Fee (CLINs 1007-5007): The Contractor shall invoice as instructed by the Contracting Officer following determination of performance incentive amounts, if any.

G-7.10. Contract Administration (CLINs 1009-5009): Upon Definitization of the respective Change Order. See G-7.12. below.

G-7.11. Transition-Out (CLINs 1010-5010): Submit invoice following completion of all transition-out requirements.

G-7.12. Modifications: The contractor may invoice for change order definitizations or other modifications after the Contracting Officer provides instructions and authorization to invoice via modification.

G-8. INVOICE AND PAYMENT OF PASS-THROUGH HEALTH CARE COSTS (NON-TEDS)

The contractor shall group and process each type of Non-TED voucher by each pass-through health care cost category identified below.

G-8.1. Capital and Direct Medical Education Costs (CAP/DME): Are paid by the contractor from the pass-through health care bank account to hospitals requesting reimbursement under the TRICARE/CHAMPUS DRG-Based Payment System (excludes children's hospitals) (see TRM Chapter 6, Section 8).

G-8.1.1. The contractor shall electronically submit a monthly CAP/DME voucher to TMA/CRM no later than the 20th calendar day of the month following receipt of the hospital's request for payment. Supporting documentation, including copies of the hospital's claim and the payment calculation, shall be submitted electronically using approved formats specified in TOM Chapter 2. Within two calendar days after receiving disbursement clearance from, TMA/CRM, the contractor shall complete the process by making payment to the hospital.

G-8.1.2. If the contractor makes an underpayment, the contractor shall determine the amount and pay any amount due to the hospital with the next group of payments being made. If the contractor overpays a hospital, the contractor shall recoup this amount and document as follows:

1. Offset funds shall be included as credits on the monthly CAP/DME voucher for the month the credits were processed.

2. Collections shall be included as credits indicating the month the collection was deposited (normally the prior month).

3. Debts established under this paragraph and related transactions shall be reported on the monthly Accounts Receivable Report.

G-8.2. Federal Fiscal Year-end Processing of Non-TED Vouchers (September month-end)

CAP/DME vouchers that are normally submitted for September in the month of October should utilize the October fiscal year check stock.

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G-8.3. Bonus Payments In Health Professional Shortage Areas (HPSA) and In Physician Scarcity Areas (PSA)

Bonus payments are in addition to the amount normally paid under the allowable charge methodology in order to provide services in medically underserved areas [Health Professional Shortage Areas (HPSA) and Physician Scarcity Areas (PSA)] See TRM, Chapter 1, Section 33). Payments will only be calculated for the United States and US Territories. On a quarterly basis the Contractor shall submit the voucher electronically as a pass-through payment. Supporting documentation including lists of doctors, their addresses, and the calculation of the payment, shall also be sent electronically based on approved formats as specified in the TOM, Chapter 2. After receiving clearance from , TMA/CRM the Contractor shall process and mail the providers check.

The voucher shall contain the following:

- a. Format for Vouchers
 - Period Covered (Quarter)
 - Physician Name
 - Physician Address
 - Physician Provider Number
 - Amount Paid/Collected for Bonus
 - Total Bonus Paid [5 and/or 10 percent of the above bullet]
 - Total of all Bonuses being paid

- b. Sort for Vouchers
 - By Contract
 - By Automated Standard Application for Payment System (ASAP) ID (Fiscal Year) of Bank Account
 - By Type (e.g., standard or active duty)
 - By Coverage (Prime, Extra, Standard)
 - By State
 - By Physician
 - By Physician Number
 - By Specialty
 - By Address & Zip
 - By Participating & Non-Participating
 - By Contracted (Network) and Not Contracted (Non-network)
 - By Modifier ("QB", "QU" or "AR")

G-8.4. Federal Fiscal Year-end Processing of HPSA Vouchers (September month-end)

HPSA vouchers that are normally submitted for September in the month of October should utilize the October fiscal year check stock.

G-8.5. Demonstrations

These are trial programs and they may vary in many ways from TRICARE benefits. TEDs will be used if possible but if the data associated with demonstrations is incompatible with TED data formats, the contractor shall submit a separate voucher to TMA/CRM no more frequently than monthly to obtain clearance to make pass-through health care bank account transactions.

G-8.6. Other Payments

Other adjustments are rare situations where a payment needs to be made but does not fall into routine processing such as TEDs, CAP/DME, etc. For example, these payments may be the result of a very old case or a legal settlement that doesn't apply to a given individual. These must be submitted to the Contracting Officer and to TMA/CRM with supporting documentation explaining the issues that don't

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allow a TED record along with the claim, computation and other applicable documents. After funding approval by TMA/CRM, the contractor shall make payment within 2 working days. The contractor shall report these payments on the Bank Reconciliation Report under TMA approved manual transactions. If these payments are determined to be invalid, the contractor may be liable for any dollar amounts involved.

G-9. Claims Processing - TEDs (CLINs 1002-5002)

G-9.1. Submission of a TED record header to TMA is considered submittal of an invoice. For purposes of determining the due date for payment under the Prompt Payment Clause, the header "end date/time" TRICARE Encounter Data (TED) submission is sent to TMA will be used to determine the date of receipt.

G-9.2. Claim Quantity: The contractor is paid the unit price for each TED record that passes all TED edits as specified in the TSM and validated by the TMA/CRM TED record edit system.

G-9.3. Unit Price (Claims Processing Fee) and Performance Period: The contractor is paid the claims processing unit price identified in Schedule B for the contract period in which the contractor originally submits the claim. The Batch/Voucher date in the voucher header is used to determine the contract period and applicable unit price.

G-9.4. Claims received by the contractor during its period of services delivery are required to be processed to completion within 180 calendar days following the end of health care delivery. There will be no claims processing fee paid to the Contractor if the 180 calendar day requirement is not met.

G-9.5. Invoice Instructions: The contractor shall submit batch/vouchers under the correct header type as specified in the TRICARE Systems Manual (TSM), Chapter 2, Section 2.3 and the TRICARE Operations Manual, Chapter 24, Section 9.

G-9.6. Upon notification by the Contracting Officer that the TED Record processing system is not operating normally, the contractor may submit invoices outside of the TED system to the Contracting Officer. The invoice shall list the number of claims processed by CLIN. This may be submitted daily or grouped by no more than five calendar days of claims. These payments will be treated as an interim payment and will be a credit to the amount due as determined by the TED Record processing system when it is operating again.

G-10. TEDS SUBMITTAL INSTRUCTIONS:

G-10.1. TEDS shall be submitted per TSM requirements and the Automated Standard Application for Payment (ASAP) System ID for pass-through health care claims. Adjustments and cancellations may be included with initial submissions.

G-10.2. Voucher Transmission Requirements: Pass-through health care batches/vouchers received after 10:00 AM Eastern Time Zone shall be considered received the next business day for payment and check release authorization purposes. Batches/Vouchers must pass all TED header edits as specified in the TSM. If all header edits are not passed, the Batch/Voucher will be rejected and returned to the contractor.

G-10.3. Voucher Integrity: Voucher header and detail amounts transmitted by the contractor become "fixed" data elements in the finance and accounting system for purposes of control and integrity. Corrections or adjustments to reported (payment) amounts must be accomplished on separate voucher transmissions.

G-10.4. Payment Suspension and TED Processing During Partial Funding Shortages:

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G-10.4.1. Some of the funding TMA receives may be restricted in use to a specific federal agency, military department and/or to a particular health care program. Funding for these special purpose programs may run out before funding for other TMA programs. Therefore, the contractor shall have the ability to suspend claims payment and the associated submission of institutional TEDS records or non-institutional TED line item(s) to TMA based on values contained in the following TED record fields:

Service Branch Classification Code (Sponsor), SBCC - As specified in the TSM, Chapter 2, Section 2.8.

Enrollment/Health Plan Code (E/HPC) - As specified in the TSM, Chapter 2, Section 2.5.

Special Processing Code (SP) - As specified in the TSM, Chapter 2, Section 2.8.

Health Care Delivery Program Coverage Code - As specified in the TSM, Chapter 2, Addendum M.

G-10.4.2. The suspension of claims payment and TED records may be based on a single value (e.g., SBCC=A) or a combination of values (e.g., SBCC=A & E/HPC=SR). Suspension of TED records (institutional) or TED line items (non-institutional) containing specific values shall be implemented by the contractor within five workdays after receiving notification from the contracting officer. On the sixth workday, TMA/CRM will implement immediate payment offset against contractor invoices of any claims paid by the contractor from their pass-through health care bank account(s) for institutional TED records or noninstitutional TED line items containing suspended value(s). The contractor shall NOT, without prior contracting officer approval, initiate payment offset against any provider or beneficiary for payments made against suspended transactions and offset by TMA/CRM on contractor invoices.

G-10.4.3. For all suspended transactions, the contractor shall hold the claim information until receiving instructions from the contracting officer to do otherwise. The contractor shall not reject the claims or return any information to the providers or beneficiaries unless instructed by the contracting officer. Once the contracting officer lifts the TED data submission restriction, the contractor may submit all withheld TED data on the next appropriate (batch/voucher) data submission. TMA/CRM will reimburse the contractor (without interest) for any invoice payment offsets done for TED suspended transaction that have not been recouped by the contractor.

G-10.5. Federal Fiscal Year-end Processing (September month-end)

G-10.5.1. All TEDS data must be received no later than 10:00 AM EST, (8:00 AM MST; 7:00 AM PST) on September 28. Any Batch/Voucher received after 10:00 AM EST will be rejected by TMA and must be resubmitted by the contractor using next fiscal year Batch/Voucher CLIN/ASAP Account Numbers. The contractor should not submit batch/vouchers with dates of September 29 and September 30. Any payment processed after September 28th, must use the next fiscal year Batch/Voucher CLIN/ASAP Account Numbers and must utilize the new fiscal year check stock, as applicable. The contractor shall not submit Batch/Vouchers to TMA between September 28, 10:00 AM Eastern Time or before October 1, 12:01 AM Eastern Time. Transmission Files (TD Files) sent on September 28th cannot exceed 300,000 records.

G-10.5.2. All payments not included in the contractor's final fiscal year data submission on September 28 must have a Batch/Voucher Date on or after October 1. Contractors will be able to test their new fiscal year's transactions in benchmark starting September 1. Like production, benchmark data must be received at TMA by 10AM EST on September 28. After 10 AM EST on September 28 until October 1, 12:01 AM Eastern Time no benchmark data can be transmitted to TMA.

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G-11. NON-FINANCIALLY UNDERWRITTEN HEALTH CARE

G-11.1. The contractor acts as a Fiscal Intermediary for the Government to distribute, or pass-through, Government funds for certain non-financially underwritten health care benefits. These are not costs to the contractor and are not reimbursed by the Government, so the contractor may not collect or hold pass-through health care funds before dissemination to the beneficiary or provider and the contractor shall return any collections to the Government.

G-11.1.1. Pass-through health care payments by the contractor on behalf of the Government will be facilitated by allowing the Contractor (through the Contractor's financial institution) to draw money from the designated Federal Reserve Bank (FRB). These draws may only be done for benefit payments that have previously been submitted on TEDs or as a non-TED, pass-through health care voucher and approved for release by TMA/CRM and are clearing the contractor's financial institution on the day the draw is being accomplished. Advance payments are not allowed. No bank fees or other bank charges shall be paid from this account and no money should be drawn from the FRB for these charges.

G-11.1.2. All payments for pass-through health care claims processed by the contractor must be approved by the TMA/CRM Budget Office before the contractor may make payments to the beneficiary or provider. Unapproved draws and payments by the contractor will be immediately collected and subject the Contractor to penalties.

G-11.2. Establishment of Pass-Through Health Care Bank Accounts

G-11.2.1. The Department of Treasury's Automated Standard Application for Payment System (ASAP), along with FEDWIRE provide a mechanism for disbursement of Government funds for health care services received by TRICARE beneficiaries that are not underwritten by the contractor. After authorization by TMA/CRM, these systems allow the contractor to draw cash directly from the Federal Reserve Bank (FRB) to cover payments as they clear the contractor's bank account. ASAP is used by the Treasury, the FRB and TMA/CRM to verify the authorization to make draws and to track transactions made by the contractor's bank. FEDWIRE is used by the contractor's bank to actually draw funds from the FRB.

G-11.2.2. The contractor shall establish bank account(s) for non-underwriting transactions with a commercial bank that has FEDWIRE capability following Treasury requirements. The contractor shall submit bank information to TMA/CRM not later than 60 calendar days prior to the beginning of processing claims on a new account. The information shall include:

- Name of Bank
- Overnight mail address
- American Banking Association (ABA) routing number
- Taxpayer Identification Number (TIN) (must be the same TIN used for payment)
- Contractor's bank account number (if separate checking and deposit accounts are used, both need to be provided)
- Individual point of contact at the bank and an alternate, including their phone numbers, fax numbers and e-mail addresses
- Individual point of contact at the contractor and an alternate, including their phone numbers, fax numbers and e-mail addresses

G-11.2.3. TMA/CRM will establish the bank account(s) on ASAP with the Treasury Department. TMA/CRM will notify the bank and the contractor once the bank account(s) have been established and provide codes or other information necessary for the bank to make draws against the FRB using FEDWIRE. Currently, ASAP has a requirement to identify a total dollar amount that may be drawn on

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the FRB. This dollar limit, established by TMA, only represents an administrative ceiling at the FRB, and does not constitute any authority to draw funds. Accounts will also have daily limits for the amount that can be drawn. The Contractor will be notified of these limits by TMA/CRM. TMA/CRM will be able to increase these limits as needed.

G-11.2.4. The contractor shall establish and use a minimum of two separate bank accounts to reimburse claims in accordance with this section. One bank account will be used for transactions related to beneficiaries who are covered by TRICARE, but not Medicare (TRICARE-only Eligible). The second bank account will be used for transactions related to dual eligible beneficiaries who are eligible for coverage under both Medicare and TRICARE (Medicare-Dual Eligible).

G-11.2.5. Contractors with more than one bank account shall ensure transactions are properly accounted for to prevent the commingling of funds. Failure to properly associate transactions with the correct bank account could result in the over-execution of TMA/CRM budget authority. Transfers of funds between bank accounts are strictly prohibited except deposits identified later as having been made to the wrong account. Any transactions reported under one bank account and identified later as belonging to a different bank account shall be reported immediately to TMA/CRM when identified. TMA/CRM will instruct the contractor as to what action to take.

G-11.3. Authorization to Release Pass-Through Health Care Payments

G-11.3.1. TED data submissions for pass-through health care payments shall be grouped into TED Vouchers by the "Batch/Voucher CLIN/ASAP Account Number" field (defined in TSM, Chapter 2, Section 2.2). The contractor shall not release pass-through health care payments without prior authorization from the TMA/CRM Budget Office. Authorization from TMA/CRM to release payments will be sent to the contractor via fax or e-mail NLT than 5:00 PM Eastern Time the day of receipt. Authorization will specify contract number, ASAP Account ID#, initial transmission received date, and total dollar amount of funds that may be released based on information contained in the Batch/Voucher header. Approval for funds release will be given provided the following criteria are met:

- Voucher submissions must pass all header edits as specified in TSM, Chapter 2, Section 2.3.
- TMA/CRM Budget Officer has confirmed that funding is available to cover payments.

G-11.3.2. Benefit payments in U.S. dollars shall be released/mailed no later than two workdays after TMA/CRM has approved the release of payments. Benefit payments via foreign drafts shall be released/mailed no later than four workdays after TMA/CRM has approved the release of payments. Check date shall be the same date as the Initial Transmission Date (derived by TMA and equal to the calendar date the Batch/Voucher was transmitted to TMA).

G-11.3.3. Authorization to release payments does not constitute TMA's acceptance that all payments are valid and/or correct. Detailed records will be audited for financial compliance. All transactions in these bank accounts must be valid and justified. Any unreported/unauthorized disbursements identified by TMA will be subject to immediate payment offset against any payments being made to the contractor. All disputed amounts will remain in the possession of the Government until no longer in dispute.

G-11.4. Draws on the Federal Reserve

G-11.4.1. The contractor shall ensure that cash draw downs do not exceed the payments authorized, as they clear the bank on a given day, less deposits. The contractor shall ensure that any excess draws are immediately returned to the

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FRB. Interest and a penalty will be charged beginning the day after the overdraw and will continue until the overdraw amount is returned. Interest will accrue daily and is based on the Treasury Current Value of Funds Rate. The penalty will accrue daily and is based on the penalty rates in the Code of Federal Regulations, Title 31, Volume 1, PART 5, Subpart B Sec.5.5. TMA/CRM may initiate immediate payment offset against any payments to the contractor involved for the interest, penalties and/or the overdrawn amount.

G-11.4.2. Contractors with more than one bank account shall ensure transactions are properly accounted for to prevent the commingling of funds. Failure to properly associate transactions with the correct bank account could result in the over-execution of TMA/CRM budget authority. Transfers of funds between bank accounts are strictly prohibited except for correcting deposits that are in the wrong account. Any transactions reported under one bank account and erroneously charged against a different bank account shall be reported immediately to TMA/CRM when identified. TMA/CRM will instruct the contractor as to what action to take.

G-11.4.3. The total amount of a cash draw down on the FRB is based on the daily total of benefit payments presented to the bank for payment. If estimates are needed due to timing of reports from check clearinghouses or the FRB, the draws shall be adjusted the next business day.

G-11.4.4. Computation of the amount of the draw must include any deposits of funds into the account. These deposits will reduce the amount of cash needed for the draw down on the day of the deposit.

G-11.5. Financial Editing of Detail Claims Data for Pass-Through Health Care Claims

The TED system allows for the categorization of claim errors based on the type or classification error failed during the edit process. TMA/CRM will use the edits specified in the TRICARE Systems Manual, Chapter 2, Section 8.1, Financial Edits, to determine the propriety of payments. TED records that fail the Financial Edits specified in the TRICARE Systems Manual, Chapter 2, Section 8.1 will be "flagged" by TMA/CRM as inadequate payment information. The contractor shall correct the claims flagged by TMA/CRM within 90 calendar days. If not corrected in 90 calendar days, TMA/CRM will send a demand letter requiring resolution or reimbursement for all claims identified through TEDs as edit failures. The contractor shall respond within 30 calendar days as to why the claim(s) in question cannot be corrected. If resolution cannot be reached between TMA/CRM and the contractor, the total amount of improper payments still in dispute will be collected by TMA/CRM. The contractor shall take no recourse against TRICARE beneficiaries or providers under the situations described in this paragraph without prior TMA approval.

G-11.6. Fiscal Year Start-up of Pass-Through Health Care ASAP Accounts

G-11.6.1. The contractor shall establish a separate bank account for each new Government fiscal year. All payments issued for benefit payments and all refunds received shall be processed against the new account effective the first day of the new fiscal year. The contractor shall also transfer all recoupment installment payments to the new account from the previous year's account.

G-11.6.2. Cash draw downs against the prior fiscal year's bank account may continue, if required, until all payments from the prior year have either cleared or have been canceled, but no longer than the end of February of the following year or five months after the last payments have been made on an account (in the case of a contract closeout).

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G-11.6.3. Bank accounts shall be closed no later than the end of February, following the fiscal year end, or one month after the last payment on an account has staledated. A final bank account reconciliation shall be made within 30 calendar days following the last authorized transactions. All transactions that were not previously approved by TMA/CRM shall be explained with supporting documentation on the final bank reconciliation report (Section F.5.1.3.). TMA/CRM reserves the right to not accept these transactions.

G-11.6.4. Any outstanding balance in the account shall be reimbursed to TMA no later than the required submission date of the final bank account reconciliation. This balance may be subject to interest if it includes overdrawn amounts that were required to be submitted at an earlier date.

G-11.7. Staledated or Voided Payments

G-11.7.1. For payments that are voided or staledated that are over \$10, a credit voucher through TEDs must be processed in accordance with the standards detailed in TOM Chapter 1, Section 3. If the check was issued as a manual voucher, the credit should be submitted as a similar manual voucher. The only exception to issuing a credit voucher would be staledates under \$10.00.

G-11.7.2. For voided/staledated payments of \$10.00 or less, the contractor may elect either to:

Affect a credit voucher for the check using automated means, or
Instead of making a voucher transaction, a memorandum record shall be prepared and included on a listing of transactions as submitted monthly in the Pass-Through Health Care Funds Bank Account Reconciliation Report.

G-11.8 Replacement Payments

G-11.8.1. Reissuance of payments will be made against the current fiscal year bank account.

G-11.8.2. Replacement payments may be issued upon request of the payee or authorized representative. If the check is not returned by the payee, the payee must provide a statement describing the loss or destruction of the check. Before a replacement check is issued, a stop payment order for the original check must have been issued and accepted by the bank.

G-11.8.3. If the claim history is not available to the contractor, the contractor shall submit a request for approval of check release to TMA/CRM within 10 workdays from the request by payee. Supporting documentation shall include the original check, the sponsor's SSN, a copy of the EOB, (if available) or other documentation showing the computation and payment of the original check, and the check or copy or statement as described in G-11.8.2. above.

G-11.8.4. The contractor shall report the reissuance using the same procedure as was used to void/staledate the original.

G-11.8.4.1. If no credit voucher was made in voiding/staledating of the check, no credit voucher is required for the reissue (i.e. if the contractor gets a returned check and immediately reissues from the same bank account, no TED or other voucher needs to be done). If the reissuance involves a check from a prior year, a TED or other voucher will need to be done to report the reissuance from the current year.

G-11.8.4.2. If the amount of the staledated check to be reissued is \$10.00 or less, the contractor shall use the same procedure in the reissuance as was used for the staledating. If no credit voucher was made in the staledating of the check, no credit voucher is required for the reissue. The contractor shall

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reissue the payment and include the amount in the Pass-Through Health Care Funds Bank Account Reconciliation Report.

G-11.8.5. Reissuance of Payments When Original Payee is Deceased

Payments issued by the contractor shall be made payable to the legal representative of the estate of the person concerned with an additional line stating "For the estate of ____." Payments shall not be payable to the "estate of" a decedent, nor to a deceased person. Payments shall be delivered to the named payee or mailed to the payee's address of record.

G-11.8.6. Procedures for Benefit Payment Release When the TED Record Processing System Is Not Available

Upon notification by the Contracting Officer that the TED Record processing system is not operating normally, the contractor will send an email or fax with a listing of specific vouchers to TMA/CRM to request release of payments. This may be done daily. TMA/CRM will return to the contractor a signed release so the contractor can pay the providers and beneficiaries without delay. The contractor must not release payments until this approval is received. Upon notification by the Contracting Officer that the TED Record processing system is operating again, this process can be discontinued. The contractor requests will include the following Header information for each voucher (See TRICARE Systems Manual, Chapter 2, Section 2.2): ELN Element Name

0-001	Header Type Indicator
0-005	Contract Identifier
0-010	Contract Number
0-015	Batch/Voucher Identifier
0-020	Batch/Voucher Number
0-025	Batch/Voucher ASAP Account Number
0-030	Batch/Voucher Date YYYYDDD
0-035	Batch/Voucher Sequence Number
0-040	Batch/Voucher Resubmission Number
0-045	Total Number of Records
0-050	Total Amount Paid

G-12. OVER/UNDER PAYMENTS AND RECOUPMENTS (TEDS) (See TOM Chapter 10)

G-12.1 Under Payments

When the Contractor makes an additional payment due to a prior underpayment, these payments shall be reported as an adjustment to the original TED record, but in the current fiscal year and current CLIN/ASAP ID regardless of the fiscal year or CLIN/ASAP ID of the original payment.

G-12.2. Overpayments

Overpayments will be collected and will be deposited into the current open bank accounts at the time the collection is made. Deposits will not be made into prior year accounts. Related TEDs transactions will be done using current year CLIN/ASAP IDs in the header.

G-12.3. Recoupments

When reporting collections the Contractor makes (whether cash or offset), it shall be accomplished as a separate credit transaction as an adjustment to the original TED record. Identified debts shall be reported on the Accounts Receivable Report in accordance with Section F-7.1.4.

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G-13. TRICARE RESERVE SELECT PREMIUMS

The contractor shall establish separate non-interest bearing accounts for the collection and disbursement of TRS premiums. The contractor shall make daily deposits of premium collections to the established account. The contractor shall wire-transfer the premium collections, net of refund payments, monthly to a specified Government account as directed by TMA/CRM Finance and Accounting Office. The Government will provide the contractor with information for this Government account. The contractor shall notify the TMA/CRM by e-mail within one business day of the deposit specifying the date and amount of the deposit. The contractor shall submit a monthly TRS report with premium activity supporting the wire transfer of dollars, including premium billings, collections, and enrollments (Section F).

(End of Section)

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H-1. UNDERWRITING OF HEALTH CARE COSTS

The Contractor is not required to underwrite the cost of civilian health care services (also referred to as "purchased care" which is defined as care rendered outside the Direct Care System) provided to beneficiaries receiving care under the scope of this contract. The Contractor acts as a Fiscal Intermediary for the Government to distribute, or pass-through, Government funds for non-underwritten health care benefits in accordance with Section G.

H-2. CONFIDENTIALITY

H-2.1. All beneficiary records, including Beneficiary History and Deductible Files as described in DoD 6025.18-R, the TRICARE Operations Manual, Chapter 1, Section 5 and other data used in any way by the Contractor must be protected as required by the Freedom of Information Act, the Privacy Act of 1974 (as implemented by Department of Defense Regulation 5400.11-R), the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act, the Health Insurance and Portability Accountability Act (HIPAA) of 1996, DOD 6025.18-R, and 10 U.S.C. 1102. With regard to confidentiality, the Contractor shall comply with the TRICARE Operations Manual, Chapter 1, Section 5. Records must be protected, in terms of privacy and security during use, transmission, storage, destruction, and handling. Unless otherwise provided herein as approved by the Contracting Officer, all records shall be used only in the performance of the contract.

H-2.2. Under the Privacy Act, it takes a court order from a court with jurisdiction over the TRICARE program for TMA records to be released. A subpoena for TMA records is not sufficient for release. The Contractor shall forward all subpoenas, and/or court orders for documents that encompass any TMA records to the COR for coordination of release with the TMA, Office of General Counsel (OGC). The COR shall coordinate release or non-release with the TMA/OGC and notify the Contractor in writing the determination of the TMA/OGC. The Contractor shall not release any TMA records without approval of the TMA/OGC.

H-3. PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

H-3.1. In accordance with DOD 6025.18-R "Department of Defense Health Information Privacy Regulation" the Contractor meets the definition of Business Associate. Therefore, a Business Associate Agreement is required to comply with both the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security regulations. This section serves as that agreement whereby the Contractor agrees to abide by all applicable HIPAA Privacy and Security requirements regarding health information as defined in this section, and DOD 6025.18R, as amended. This agreement is in addition to, and does not supersede, any agreement required in this contract. Additional requirements will be addressed when implemented.

H-3.2. The Contractor agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information except as permitted by this contract.

H-3.3. The Contractor agrees to use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits in the execution of this contract.

H-3.4. The Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to the Contractor of a use or disclosure of Protected Health Information in violation of the requirements of this contract.

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H-3.5. The Contractor agrees to report to the Government any security incident involving protected health information of which it becomes aware.

H-3.6. The Contractor agrees to report to the Government any use or disclosure of the Protected Health Information not provided for by this contract of which the Contractor becomes aware.

H-3.7. The Contractor agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by the Contractor on behalf of the Government agrees to the same restrictions and conditions that apply through this contract to the Contractor with respect to such information.

H-3.8. The Contractor agrees to ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information, agrees to implement reasonable and appropriate safeguards to protect it.

H-3.9. The Contractor agrees to provide access, at the request of the Government, and in the time and manner designated by the Government, to Protected Health Information in a Designated Record Set. This access shall be provided to the Government, or as directed by the Government, to an Individual in order to meet the requirements under 45 CFR 164.524.

H-3.10. The Contractor agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Government directs or agrees to pursuant to 45 CFR 164.526 at the request of the Government or an Individual, and in the time and manner designated by the Government at no increase in contract price or cost.

H-3.11. The Contractor agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by the Contractor on behalf of, the Government, available to the Government, or at the request of the Government to the Secretary, in a time and manner designated by the Government or the Secretary, for purposes of the Secretary determining the Government's compliance with the Privacy Rule.

H-3.12. The Contractor agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for the Government to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

H-3.13. The Contractor agrees to provide to the Government or an Individual, in time and manner designated by the Government, information collected in accordance with this section of the Contract, to permit the Government to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

H-3.14. **General Use and Disclosure Provisions.** Except as otherwise limited in this section, the Contractor may use or disclose Protected Health Information on behalf of, or to provide services to, the Government for treatment, payment, or health care operations purposes, in accordance with the specific use and disclosure provisions below, if such use or disclosure of Protected Health Information would not violate the Privacy Rule, the Security Rule or DOD 6025.18-R if done by the Government.

H-3.15. Specific Use and Disclosure Provisions

H-3.15.1. Except as otherwise limited in this section, the Contractor may use Protected Health Information for the proper management and administration of the contract or to carry out the legal responsibilities of the Contractor.

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H-3.15.2. Except as otherwise limited in this section, the Contractor may disclose Protected Health Information for the proper management and administration of this contract, provided that disclosures are required by law, or the Contractor 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 Contractor of any instances of which it is aware in which the confidentiality of the information has been breached.

H-3.15.3. Except as otherwise limited in this section, the Contractor may use Protected Health Information to provide Data Aggregation services to the Government as permitted by 45 CFR 64.504 (e) (2) (i) (B).

H-3.15.4. The Contractor may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502 (j) (1).

H-3.16. Actions of the Government

H-3.16.1. Upon request, the Government will provide the Contractor with the notice of privacy practices that the Government produces in accordance with 45 CFR 164.520; as well as any changes to such notice.

H-3.16.2. The Government will provide the Contractor with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, if such changes affect the Contractor's permitted or required uses and disclosures.

H-3.16.3. The Government will notify the Contractor of any restriction to the use or disclosure of Protected Health Information that the Government has agreed to in accordance with 45 CFR 164.522, except for providing Data Aggregation services to the Government and for management and administrative activities of the Contractor as otherwise permitted by this section.

H-3.17. **Permissible Requests by the Government.** The Government will not request the Contractor to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by the Government.

H-3.18. The Government reserves its rights and remedies set forth in the Inspection of Services clause (FAR 52.246-4, 52.246-5) and the Default clause (FAR 52.249-8, 52.249-6) if any non-conformance with these requirements by the Contractor should occur.

H-3.19. **Effect of Termination/Conclusion of Contract.** All records subject to this section should be handled in accordance with the records management requirements of this contract. Notwithstanding the records management requirements, the Contractor shall return or destroy all Protected Health Information received from the Government, or created or received by the Contractor on behalf of the Government. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of the Contractor. The Contractor shall retain no copies of the Protected Health Information.

H-3.20. **Regulatory References.** A reference in the requirements of this section to a section in DOD 6025.18-R, Privacy Rule or Security Rule means the section as in effect or as amended, and for which compliance is required.

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H-3.21. Survival. The respective rights and obligations of Business Associate under the "Effect of Termination" paragraph of this section shall survive the termination of this Contract.

H-3.22. Interpretation. Any ambiguity in this section shall be resolved in favor of a meaning that permits the Government to comply with DOD 6025.18-R, HHS Privacy Rule or HHS Security Rule.

H-4. COMPLIANCE WITH FEDERAL, STATE, LOCAL, AND FOREIGN REQUIREMENTS

H-4.1. The Contractor shall comply with all applicable state insurance and license requirements necessary for performance under this contract except where preempted by Federal Law. Both the Department of Defense Appropriations Act, 1994 (Public Law 103-139) and the Defense Authorization Act for Fiscal Year 1994 (Public Law 103-160) (Codified at 10 USC 1103) provide for preemption of state and local laws that relate to health insurance, prepaid health plans, or other health care delivery or financing methods. In order to identify those state and local laws that should be preempted, the Contractor is directed to notify the Contracting Officer of those state and local laws the Contractor deems should be preempted, with supporting documentation. This notification should be provided no later than 30 calendar days after award of the contract. The Contractor may also be required to comply with foreign laws, depending on their business structure and physical location of services.

H-4.2. In addition to the insurance and license requirements the Contractor, consultants, and providers shall obtain and maintain all other permits, licenses, etc., that may be required to perform the services set forth in Section C.

H-5. OTHER TERMS, CONDITIONS AND PROVISIONS

H-5.1. Protection of Information

H-5.1.1. Security. The Contractor does not require access to classified data, however, the Contractor may require access to information, which is to be handled as "For Official Use Only", and which may be covered by the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA). The Contractor shall ensure that staffs assigned to this task understand the meaning of these categories of data and handle them accordingly.

H-5.1.2. DEERS Personnel Security Requirements. The Contractor shall comply with the requirement to obtain ADP II personnel security investigations as prescribed by DoD 5200.2-R for Contractor/subcontractor personnel that will be accessing DEERS via the Government provided eligibility inquiry tool. The appropriate investigation forms, finger print cards, and questionnaires shall be completed as required and submitted to the appropriate Government Security Office for processing. Access to Government provided eligibility inquiry tool will not be granted until appropriate paperwork and questionnaires have been submitted to the Government. If at any time the individual receives unfavorable NAC adjudication, or if at any time information that would result in an unfavorable NAC becomes known, the Contractor shall immediately remove the employee from non-critical sensitive positions. Non-US citizens will not be granted access to the Government provided eligibility inquiry tool.

H-5.1.3. Dissemination of Information/Publishing. There shall be no dissemination or publication, except within and between the Contractor and any subcontractors or specified Integrated Process Team (IPT) members who have a need to know, of information developed under this contract or contained in the reports to be furnished pursuant to this contract without prior written approval of the TMA COR or the Contracting Officer. TMA approval for publication will

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require provisions which protect the intellectual property and patent rights of both TMA and the Contractor.

H-5.1.4. Identification of Contractor Employees. All contract personnel attending meetings, answering Government telephones, and working in other situations where their Contractor status is not obvious to third parties are required to identify themselves as such to avoid creating an impression in the minds of members of the public or Congress that they are Government officials, unless, in the judgment of the agency, no harm can come from failing to identify themselves. They must also ensure that all documents or reports produced by Contractors are suitably marked as Contractor products or that Contractor participation is appropriately disclosed.

H-6. PERFORMANCE INCENTIVES

H-6.1. Introduction. This section addresses the positive and negative incentives that have been incorporated into this contract. The Contractor may receive a performance incentive payment by either exceeding a minimum standard, or for performance above a fully satisfactory level in the areas of program integrity and claims accuracy. If the Contractor fails to meet the minimum standard for network adequacy, a negative incentive will be applied. The administration of incentives described herein is assessed before any 3rd party claims audits.

H-6.1.1. Incentive Administration. Contractor performance for a given option period will be measured after completion of each option period. When performance exceeds the standard or exceeds the fully satisfactory level described below for program integrity and/or claims accuracy, the Government applies the stated incentive amount into the applicable performance incentive pool in Section B for payment. If the Contractor fails to meet the minimum standard for network adequacy, the amount in the performance incentive pool will be reduced, or the payments from the performance incentive pool offset by the amounts described in this section. If the offset amount is greater than any earned incentive, the Contracting Officer will deduct that amount from the next payment to the Contractor under this contract. After the Government has completed measurement, and the Contracting Officer notifies the Contractor, the Contractor is paid the net amount in the performance incentive pool, if any. The Government may obligate funds into the performance incentive pool in advance as the Contracting Officer determines necessary to ensure sufficient funds are available to pay performance incentives to the Contractor after the option period is completed.

H-6.2. Program Integrity. A Contractor's Program Integrity efforts will be incentivized through the referral of fraud and abuse cases to TMA in accordance with Chapter 13 of the TOM. Within 60 calendar days following the end of each Option Period, the Government will evaluate the Contractor's performance against the requirements described in Sections H-6.2.1 and H-6.2.2 to determine whether the Contractor's level of performance warrants an incentive payment. This incentive can only result in either no payment or a positive payment amount.

H-6.2.1. The Contractor must meet all requirements contained in Chapter 13 of the TOM (as determined by TMA Office of Program Integrity) to be considered eligible for a positive incentive payment for the referral of cases as described in Section H-6.2.2 below. The evaluation and monitoring of this performance will be accomplished by the TMA Program Integrity Technical Representatives with input obtained from the Director, Program Integrity, Program Integrity staff members and Program Integrity customers such as DCIS, DOJ, and other law enforcement/legal personnel.

H-6.2.2. If the requirements of Section H-6.2.1 are met, a positive incentive will be applied to performance that results in the referral of at least 11 cases

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accepted by TMA Office of Program Integrity that are rated "five" on a quality scale (as described in the TRICARE Operations Manual, Chapter 13). The rating of the individual cases will be accomplished by TMA Office of Program Integrity and will be based on analysis of the case referral as follows: does the case identify a pattern of fraud or abuse; have the allegations been substantiated; how has TRICARE been affected (monetarily, patient harm, etc); is the case referral complete (thoroughly documented with evidentiary data); was appropriate back-up information included (audit files, provider files, correspondence, etc); and was the applicable TRICARE regulation and/or policy cited and included in the package. The PI "Case Referral Evaluation" sheet will be used to rate each referral and can be found at Chapter 13, Addendum A.

H-6.2.3. The positive incentive payment amount for program integrity referrals will be:

- 11-15 cases referred with a "5" rating assigned: \$180,000.00
- 16-20 cases referred with a "5" rating assigned: \$240,000.00
- 21 or more cases referred with a "5" rating assigned: \$300,000.00

H-6.2.4. Rating criteria: The rating of the individual cases will be based on the Government's analysis of the case referral as follows: does the case identify a pattern of fraud or abuse; have the allegations been substantiated; how has TRICARE been affected (monetarily, patient harm, etc); is the case referral complete (thoroughly documented with evidentiary data); was appropriate back-up information included (audit files, provider files, correspondence, etc); and was the applicable TRICARE regulation and/or policy cited and included in the package. The PI "Case Referral Evaluation" sheet will be used to rate each referral and can be found at TOM Chapter 13, Addendum A. All case ratings will be determined by the Government solely based on the information within the initial case submittal. Any information, rebuttals, or arguments provided by the Contractor subsequent to the initial submittal of a case will not be considered for the rating determination. Any case prepared, dated, or submitted prior to the start date of the delivery of care under this contract will not be considered for this incentive. If, in the opinion of the Contracting Officer, a newly referred case should reasonably have been referred under a separate contract, that case will not be considered for an incentive. The rating assignment by the Contracting Officer is final and unappealable.

H-6.2.5. The Contractor is not eligible to receive any incentive payment for program integrity efforts, regardless of the number of referrals submitted to TMA, if the Contractor fails to comply with any of the requirements of the TOM, Chapter 13.

H-6.3. **Claims Accuracy Standard:** The absolute value of the payment errors for sampled TEDs (initial submissions, resubmissions, and adjustments/cancellation submissions) shall not exceed 1.5%.

H-6.3.1. When the Contractor decreases the payment error rate to 1.0% or below (based on sampled TEDs), they are awarded a percentage of the amount available under the incentive fee CLIN for claims accuracy. Within 60 workdays following the end of each Option Period, the Government will evaluate the Contractor's performance to determine whether the Contractor's level of performance warrants an incentive payment. This incentive can only result in either no payment or a positive payment amount. The maximum incentive that can be paid out per Option Period is 2% of the Contractor's total administrative payment for claims processing for that Option Period.

H-6.3.2. The positive incentive payment amount for payment error rates of 1.0% or below will be:

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- If more than 0.75% and less than or equal to 1.0% = 50% of the available funding
- If more than 0.50% and less than or equal to 0.75% = 75% of the available funding
- If less than or equal to 0.50% = 100% of the available funding

For example, if the available funding is \$500,000 per option period for claims accuracy incentives, and the Contractor's error rate is 0.75% (based on sampled TEDs), the Contractor is eligible for a positive incentive payment of \$375,000. Amounts not awarded will not be available during the follow on option periods.

H-6.4. Network Adequacy (Percent of TOP Prime/TOP Prime Remote Claims from a Host Nation Network Provider) Standard: The Contractor shall establish targets for the percentage of paid claims submitted by network host nation providers for TOP enrollees (including TOP Prime and TOP Prime Remote) for Option Period 1. Separate targets shall be established for MTF areas and remote areas. These target percentages shall be used as the baseline standard for this performance incentive and shall be binding on the Contractor. Beginning in Option Period 2, the target percentage of paid claims submitted by host nation network providers for TOP enrollees shall be increased by the percentages shown below. Performance will be measured based on the number of host nation network provider claims for TOP enrollees compared with the total number of host nation provider claims for these beneficiaries, after excluding emergency claims, point-of-service claims, claims for care provided in the 50 United States and the District of Columbia, and claims from enrollees with other primary health insurance (including National Health Insurance). This incentive can only result in either no payment or a negative payment amount.

- Option Period 2: Target = OP1 target (as established by Contractor) plus 2%
- Option Period 3: Target = OP2 target plus 2%
- Option Period 4: Target = OP3 target plus 1%
- Option Period 5: Target = OP4 target plus 1%

H-6.4.1. Beginning in Option Period 2, if the percentage of network versus total claims for TOP enrollees meets or exceeds the specified standard for a given option period, no negative incentive will be applied. If the percentage of network versus total claims for TOP enrollees falls below the specified standard for a given option period, a negative incentive will be applied on a per-claim basis. Within 60 workdays following the end of each Option Period, the Government will evaluate the Contractor's performance to determine whether the Contractor's level of performance warrants the application of a negative incentive. This will be done according to a series of percentage corridors, with larger negative incentives applied for successively larger discrepancies between the standard and the observed level of performance.

H-6.4.2. The amount assessed per claim when the percentage of network versus total claims for TOP enrollees falls below the specified standard is based on the percentage below the standard as follows:

Option Period 2:

- If less than OP2 target and more than or equal to OP2 target minus 3% = \$7.00 per claim
- If less than OP2 target minus 3% and more than or equal to OP2 target minus 5% = \$14.00 per claim
- If less than OP2 target minus 5% and more than or equal to OP2 target minus 6% = \$21.00 per claim
- If less than OP2 target minus 6% = \$28.00 per claim

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Option Period 3:

- If less than OP3 target and more than or equal to OP3 target minus 3% = \$7.00 per claim
- If less than OP3 target minus 3% and more than or equal to OP3 target minus 5% = \$14.00 per claim
- If less than OP3 target minus 5% and more than or equal to OP3 target minus 6% = \$21.00 per claim
- If less than OP3 target minus 6% = \$28.00 per claim

Option Period 4:

- If less than OP4 target and more than or equal to OP4 target minus 3% = \$7.00 per claim
- If less than OP4 target minus 3% and more than or equal to OP4 target minus 5% = \$14.00 per claim
- If less than OP4 target minus 5% and more than or equal to OP4 target minus 6% = \$21.00 per claim
- If less than OP4 target minus 6% = \$28.00 per claim

Option Period 5:

- If less than OP5 target and more than or equal to OP5 target minus 3% = \$7.00 per claim
- If less than OP5 target minus 3% and more than or equal to OP5 target minus 5% = \$14.00 per claim
- If less than OP5 target minus 5% and more than or equal to OP5 target minus 6% = \$21.00 per claim
- If less than OP5 target minus 6% = \$28.00 per claim

For example, if the Contractor establishes 61% as the network target in Option Period One, the network target for Option Period Two is 63% (OP1 target plus 2%). If the actual percent of TOP Prime enrollee claims from a host nation network provider in Option Period Two is 59%, then a negative performance incentive equal to 4% of the claims will be assessed (4% represents the difference between the actual number of claims for care provided by a network provider and the standard). If 4% equates to 200 claims not meeting the standard, the performance incentive assessment will be \$2,800.00, or 200 claims times \$14.00. In determining the performance incentive, the applicable amount will be determined based on the Contractor's actual performance. For instance, in the example above, the Contractor's actual performance was 59%, so the performance incentive will equal \$14.00 for every claim falling below the minimum performance standard of 63%. In other words, the highest per claim amount will be applied to all claims failing the standard. The Government will not stratify the performance incentive based on the variable per claim amounts. For purposes of performance incentive assessment, actual percentages will be rounded to the nearest one-tenth of a percent; actual percentages less than five-tenths of a percent will be rounded down, and percentages equal to or greater than five-tenths of a percent will be rounded up.

H-7. PERFORMANCE GUARANTEES

H-7.1. Introduction. The performance guarantee described in this provision is the Contractor's guarantee that the Contractor's performance will not be less than the performance standards described below. The Contractor has proposee a dollar amount that was no lower than five percent (5%) and no more than eight percent (8%) of the proposed administrative price for all prices CLINs for each

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option period of this contract as the total performance guarantee. These amounts are in Section H-7.4.

H-7.2. Rights and Remedies. The rights of the Government and remedies described in the Performance Guarantee section are in accordance with, and in addition to all other rights and remedies of the Government. Specifically, the Government reserves the rights and remedies set forth in the Inspection of Services clause (FAR 52.246-4, 52.246-5) and the Default clause (FAR 52.249-8, 52.249-6).

H-7.3. Performance Guarantee Administration. The Contractor guarantees that performance will meet or exceed the standards in this provision. For each occurrence the Contractor fails to meet each guaranteed standard, the Government will withhold from the Contractor the amount listed for each standard below. The total option period amount will be divided equally among the stated performance guarantees. Assessments for a specific performance guarantee will continue until the guarantee amount for the respective guarantee (i.e., one-sixth of the total option period amount) is depleted or the Contractor's performance improves to meet or exceed the standard. Performance will be measured as specified below. The Contractor will be notified of performance guarantee withholds on a semiannual basis via a unilateral modification in accordance with FAR 43.103(b)(3), with this section as the cited authority for the modification. Withholds will be made from the next available contract payment under an administrative line item. The amount of the performance guarantee will not change after contract award. For the purposes of this provision, the term "performance standard" is defined as the contract standards that are restated in this provision. For purposes of performance guarantee assessment, actual percentages will be rounded to the nearest one-tenth of a percent; actual percentages less than five-tenths of a percent will be rounded down, and percentages equal to or greater than five-tenths of a percent will be rounded up.

H-7.4. Performance Guarantee Amounts:

Option Period 1
Option Period 2
Option Period 3
Option Period 4
Option Period 5



H-7.5. Performance Guarantee #1: Telephone Service (Telephone Answering Speed).

H-7.5.1. Standard: When a telephone call is transferred to/answered by an individual, 90% of all calls shall be answered by an individual (not an answering machine/automated voice unit) within 30 seconds.

H-7.5.2. Administration: For each month the minimum telephone answering speed is not met, a performance guarantee shall be applied as follows: Based on the Contractor's monthly telephone report, the Government will assess a performance guarantee of \$0.50 per telephone call not meeting the standard. For example, if the actual percent of calls answered within 30 seconds is 87%, then a performance guarantee equal to 3% of all calls will be assessed (3% represents the difference between the actual number of calls not answered within 30 seconds and the standard). If 3% equates to 1000 calls not meeting the standard, the performance guarantee withhold will be \$500.00, or 1000 calls times \$0.50.

H-7.5.3. "All calls" is defined as any call to any Contractor operated TRICARE customer service telephone number. "Customer service" shall be interpreted in the broadest terms including, but not limited to, calls from beneficiaries, providers, Government representatives, interested parties about general program

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information, host nation providers, enrollment, eligibility, benefits, referrals, preauthorizations/authorizations, claims, complaints, processes and procedures.

H-7.6. Performance Guarantee #2: Telephone Service (Initial Call Resolution Rate).

H-7.6.1. Standard: 85% of all inquiries shall be fully and completely answered during the initial telephone call. (Also applies to all calls transferred to an individual.)

H-7.6.2. Administration: For each month the call resolution rate is not met, a performance guarantee shall be applied as follows: Based on the Contractor's monthly telephone report, the Government will assess a performance guarantee amount of \$0.50 for all calls that are not fully and completely answered during the initial telephone call that is below the 85% standard. For example, if the actual percent of calls fully and completely answered during the initial call is 83%, then a performance guarantee equal to 2 percent of all calls will be assessed (2% represents the difference between the actual number of calls not answered during the initial call and the standard). If 2% equates to 500 calls not meeting the standard, the performance guarantee withhold will be \$250.00, or 500 calls times \$0.50.

H-7.7. Performance Guarantee #3: Telephone Service (Call Resolution)

H-7.7.1. Standard: 99.5% of all telephone inquiries not fully and completely answered initially shall be fully and completely answered within 10 workdays.

H-7.7.2. Administration: For each month the standard is not met, a performance guarantee shall be applied as follows: Based on the Contractor's monthly telephone report, the Government will assess a performance guarantee amount of \$0.50 for each call that is not fully and completely answered within 10 workdays that is below the above standard of 99.5%. For example, if the actual percent of calls not fully and completely answered within 10 workdays is 99%, then a performance guarantee equal to 0.5% of the calls not responded to will be assessed (0.5% represents the difference between the actual number of calls not answered within 10 workdays and the standard). If 0.5% equates to 100 calls not meeting the standard, the performance guarantee withhold will be \$50.00, or 100 calls times \$0.50.

H-7.7.3. Independent Application of Call Resolution Performance Guarantees: A performance guarantee assessment will be applied independently to each call resolution standard for telephone calls (Performance Guarantees 2 and 3) that fail to meet the minimum performance. For example, a telephone call that received a performance withhold because the 85% standard was not met, is again subject to withhold if it is not responded to within 10 workdays (and the Contractor's performance is below the minimum standard of 99.5%).

H-7.8. Performance Guarantee #4: Claims Processing Timeliness (21 calendar days)

H-7.8.1. Standard: 85% of retained claims and adjustment claims shall be processed to completion within 21 calendar days from the date of receipt.

H-7.8.2. Administration: For each month that the claims processing timeliness standard is not met, a performance guarantee shall be applied as follows: Based on data from the TMA TEDs data base, the Government will assess a performance guarantee amount of \$1.00 per claim not meeting the 85% standard. For example, if the actual percent of retained claims processed in 21 calendar days is 81%, a performance guarantee equal to 4% of the retained claims processed that month will be assessed (4% represents the difference between the actual performance of

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81% and the standard of 85%). If 4% equates to 600 retained claims not processed in 21 calendar days, the performance guarantee withhold will be \$600.00, or 600 times \$1.00.

H-7.8.3. Processing Time Calculation: The Government will calculate the claim processing time based on data submitted on TEDs. The processing time is calculated as one plus the difference between the Julian date that the claim or adjustment claim was processed to completion and the Julian date of receipt or the Julian date the claim was identified as an adjustment. Only a single processing time will be calculated per claim. This processing time will be calculated using all unedited TEDs initial submission batch/vouchers (Batch/Voucher Resubmission Number equals zero) which are received by TMA during the reporting period and which pass the batch/voucher header edits. TEDs in batches/vouchers which fail the batch/voucher header edits or which are otherwise unprocessable as submitted by the Contractor and TEDs in resubmission batch/vouchers (Batch/Voucher Resubmission Number is greater than zero) will be excluded from the claim processing time calculation.

H-7.9. Performance Guarantee #5: Claim Processing Timeliness (90 calendar days)

H-7.9.1. Standard: 100% of all claims (both retained and excluded, including adjustments) shall be processed to completion within 90 calendar days unless the COR or the Contracting Officer Technical Representative (COTR) specifically directs the Contractor to continue pending a claim or group of claims.

H-7.9.2. Administration: For each month that the claims processing timeliness standard is not met, a performance guarantee shall be applied as follows: Based on data from the TMA TEDs data base, the Government will assess a performance guarantee amount of \$1.00 per claim in excess of the 100% standard. For example, if the actual percent of all claims processed in 90 calendar days is 98%, a performance guarantee equal to 2% of all claims processed that month will be assessed (2% represents the difference between the actual performance of 98% and the standard of 100%). If 2% equates to 450 claims not processed in 90 calendar days, the performance guarantee withhold will be \$450.00, or 450 times \$1.00.

H-7.9.3. Processing Time Calculation: The Government will calculate the claim processing time based on data submitted on TEDs. The processing time is calculated as one plus the difference between the Julian date that the claim or adjustment claim was processed to completion and the Julian date of receipt or the Julian date the claim was identified as an adjustment. Only a single processing time will be calculated per claim. This processing time will be calculated using all unedited TEDs initial submission batches/vouchers (Batch/Voucher Resubmission Number equals zero) which are received by TMA during the reporting period and which pass the batch/voucher header edits. TEDs batches/vouchers which fail the batch/voucher header edits or which are otherwise unprocessable as submitted by the Contractor and TEDs in resubmission batches/vouchers (Batch/Voucher Resubmission Number is greater than zero) will be excluded from the claim processing time calculation.

H-7.9.4. Independent Application of Claims Processing Timeliness Performance Guarantees: A performance guarantee assessment will be applied independently to each claim processing timeliness performance guarantee (Performance Guarantees 4 and 5) for claims that fail to meet the minimum performance. For example, a retained claim that received a performance withhold because the 85% in 21-day standard was not met, is again subject to withhold if it is not processed in 90 calendar days (and the Contractor's performance is below the minimum standard of 100%).

H-7.10. Performance Guarantee #6: TED Edit Accuracy

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H-7.10.1. Standard: The accuracy rate for TED edits shall not be less than 90% in months seven through nine of performance during the first option period, 95% in months ten through eleven, 96% in months twelve through twenty-three, and 97% in month twenty-four through contract close.

H-7.10.2. Administration: Beginning in month seven of Option Period 1, for each month that the accuracy rate for TED edits is not met, a performance guarantee shall be applied as follows: Based on data from the TMA TEDs data base, if the Contractor fails to meet the standard, a performance guarantee amount of \$3.00 for each TED record not meeting the standard will be assessed. For example, if only 85% of all TEDs pass editing in month seven, then a performance guarantee amount equal to 5% of all TEDs submitted during the month will be assessed (5% equals the difference between the Contractor's actual performance and the standard in this example). If 5% equates to 1,000 TEDs, the performance guarantee amount will be \$3,000.00 or 1,000 times \$3.00.

H-8. AWARD FEE. The Government shall develop an award fee plan and provide it to the contractor at least 90 calendar days prior to the start of health care delivery. The award fee elements will be based upon the objectives of the contract.

H-8.1. The Government will match dollar for dollar the amount pledged by the Contractor as a performance guarantee as an award fee pool amount. For example, if the Contractor proposed a performance guarantee of \$500,000, which is equal to 5% of their administrative price, then the award pool fee will be \$500,000. If the Contractor proposed a performance guarantee of \$800,000, which is equal to 8% of their administrative price, then the award fee pool will be \$800,000. The award fee pool amount will not change after contract award.

H-8.2. The award fee will be administered two times per contract option period (semi-annually) in accordance with the award fee plan. The award fee pool is prorated into two equal amounts as shown in Section B and awarded portions, if any, shall be disbursed two times each contract option period in accordance with the award fee plan. Unawarded portions of the award fee pool do not carry forward and are not available for any subsequent award. The award fee plan shall remain in effect through the life of the contract unless modified by the CO at least 60 calendar days prior to the beginning of an award fee period.

H-9. TMA CLAIMS PROCESSING AUDITS AND AUDIT METHODOLOGY

H-9.1. Claim Cycle Time Measurement. The Government will calculate claims cycle time based on data submitted on TRICARE Encounter Data (TEDs). The cycle time is calculated as one plus the difference between the Julian date of receipt or the Julian date the claim was identified as an adjustment. Only a single cycle time will be calculated per claim. This cycle time will be calculated using all unedited TEDs initial submission vouchers (Voucher Resubmission Number equals zero) which are received by TMA during each quarter and which pass the voucher header edits. TEDs in vouchers which fail the voucher header edits or which otherwise are unprocessable as submitted by the Contractor and TEDs in resubmission vouchers (Voucher Resubmission Number is greater than zero) will be excluded from the claim cycle time calculation.

H-9.2. Quarterly Claim Audit Sampling Methodology and Error Determinations.

H-9.2.1. Sampling Methodology: Sample means will be used as point estimates of payment and occurrence errors. There will be three types of payment samples; one occurrence sample and two payment samples (one for non-denied claims and one for denied claims). The occurrence samples will be drawn from TEDs records which pass TMA validity edits. Records to be sampled for both the occurrence and payment audits will be "net" records (i.e., the sum of transaction records

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available at the time the sample was drawn related to the initial transaction record). The payment samples will be drawn from TEDs records which pass all TMA edits. Payment samples will be drawn from all records with Government payments or billed amounts greater than zero and less than \$200,000, although the Government may choose to exclude certain claims strata from the sampling frame. In addition, the Government will conduct a one-hundred percent (100%) audit of all claims with payment amounts or billed amounts of over \$200,000. Payment samples will be stratified at multiple levels, either by payment amount, billed amount, or by other claims-based parameters, such as type of care and/or type of provider. TEDs in batches/vouchers which fail TRICARE edits or which are otherwise unprocessable as submitted by the Contractor will be excluded from the sampling frame. The payment sample audit results will be used to determine the Performance Incentive for Claims Accuracy as stipulated in Section H-7.3.

H-9.2.2. Required Contractor Documentation: Upon receipt of the TEDs Internal Control Number (ICN) listing and TED Detail Audit Report (TADR) from TMA or designated audit Contractor(s), the Contractor shall retrieve and compile processing documentation for each selected claim. The Contractor shall submit one legible copy of each claim and the following required documents via registered mail, certified mail or similarly guaranteed delivery service. All documentation must be received at TMA or designated audit Contractor(s) within 45 calendar days from the date of the TMA or designated audit Contractors' letter transmitting the ICN and TADR listing:

H-9.2.2.1. Claim-related correspondence when attached to claim or related to the adjudication action, such as status inquiries, written and/or telephone, development records, other telephone conversation records.

H-9.2.2.2. Other claim-related documentation, such as medical reports and medical review records, coding sheets, all authorization and referral forms and their supporting documentation, referrals for civilian medical care, other health insurance and third party liability documents, discounted rate agreements to include the following information: 1) provider name, 2) provider identification number, 3) effective and termination dates of agreements; 4) applicable pricing information, to include negotiated rate(s), per diem rate(s), prevailing Government-directed rates, DRG, OPPS, SNF; and 5) other documents as are required to support the action taken on the claim.

H-9.2.2.3. A copy of the EOB (or EOB facsimile) for each claim selected.

H-9.2.2.4. The Contractor shall send via electronic data input the current family history (15 to 27 months) for each selected claim. This electronic data containing all required data fields must be received by TMA or designated audit Contractor(s) within 45 calendar days from the date of the TMA or designated audit Contractor's letter transmitting the ICN and TADR listing.

H-9.2.2.5. Payment errors or occurrence errors will be assessed if a claim is selected for audit and the Contractor cannot produce the claim (including the above claim-related documents) or if the claim provided is not auditable. For TEDs which do not represent a legitimate condition requiring submission of a record as defined in the TRICARE Systems Manual, a 100 percent error will be assessed. The payment error amount will be based upon the total Government Pay Amount. This condition is considered to be an unsupported TED. The Contractor has the option of submitting the original document in those cases where a legible copy cannot be obtained. TMA or designated audit Contractor(s) will return original documents upon completion of the audit process.

H-9.2.3. Additional Data to be furnished by the Contractor.

H-9.2.3.1. Description of data elements by field position in family history file printout and field definitions for pricing, OHI, authorization, and

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referral screens. Initial submission to TMA is due by the commencement of claims processing; any revisions shall be submitted to TMA as they occur, but not later than the 5th work day of the month following the change.

H-9.2.3.2. Claim adjudication guidelines used by processors; automated prepayment utilization review screens; automated duplicate screening criteria and manual resolution instructions shall be submitted to TMA by the commencement of claims processing; any revisions shall be submitted to TMA as they occur, but not later than the 5th work day of the month following the change.

H-9.2.3.3. Unique internal procedure codes with narrative and cross-reference to approved TRICARE codes and pricing manuals used in claims processing. Initial submission to TRICARE is due by the commencement of claims processing and revisions as they occur, but not later than the 5th work day of the month following the change.

H-9.2.3.4. Specifications for submission of the provider and pricing files are described in the TRICARE Systems Manual. Initial submission to TMA is due by the commencement of claims processing and updates to the files are to be submitted as specified in the TRICARE Systems Manual.

H-9.2.3.5. Documentation for any claim selected with adjustment transactions completed prior to the date of the sample must include the documentation to indicate both initial and adjustment processing actions, to include claims EOBs and pricing information.

H-9.2.3.6. Documentation to support beneficiary approved participation in any TRICARE demonstration program.

H-9.3. Quarterly Payment Error and Process Error Determinations.

H-9.3.1. There are two categories of payment errors: (1) a payment error which cannot be removed by Contractor post payment processing actions and (2) a payment error which can be removed by Contractor post payment processing actions (see list of audit error codes defining payment error categories in Sections H-9.5.6 and H-9.5.7). Payment errors which can be removed by Contractor post payment actions will also be assessed a process error at audit. If Contractor post payment actions substantiate the initial processing decision, the payment error will be removed but the process error will remain. If the initial processing action is not substantiated, both the payment and the process error will remain. Claims containing process errors will not affect payment or occurrence error rates, but will be used as a performance indicator.

H-9.3.2. Payment errors are the amount of over/under payments on a claim, including but not limited to a payment in the correct amount but sent to the wrong payee, denial of a payable claim, misapplication of the deductible, payment of a noncovered service/supplies, or services/supplies for which a benefit determination cannot be based on the information available at the time of processing. Process errors result from: noncompliance with a required procedure or process, such as development required but not performed, medical emergency not substantiated, medical necessity review not evident and are cited in conjunction with a payment error. Process error determinations are based on the claim information available and those processing actions which have passed the TMA TED Validity edits up to the time the audit sample is pulled.

H-9.3.3. Payment errors which may not be removed by Contractor post payment actions (see audit error categories) are based only on the claim information available and those processing actions which have passed the TMA TED Validity edits up to the time the audit sample is pulled. Consideration will be given to subsequent processing actions that occur prior to the date the audit sample is pulled, including actions that have not passed the TMA TED edits, only if

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supporting documentation (to include the action taken and the date the action was completed) is submitted with audit documentation. Actions and determinations occurring subsequent to the date the audit sample is pulled will not be considered in the audit regardless of whether resolution of a payment error exists. Adjustment transactions are not allowed on total claim denials; therefore, subsequent reprocessing actions to a denied claim which occurs prior to the date the audit sample is pulled will be considered during the audit.

H-9.3.4. All incorrectly coded financial fields on a TED are considered to be occurrence errors regardless of whether associated errors exist.

H-9.4. Computation of the "Total Amount Billed" for Non-Denied Institutional Claims

H-9.4.1. For treatment encounters for which no per diem, negotiated rate, Government-directed rate, or DRG-based amount applies for consideration of payment, the "total amount billed" is the actual amount billed on the claims. This applies to treatment encounters involving services from DRG-exempt hospitals and hospital units, those involving DRG-exempt services and those which would otherwise be subject to the DRG-based payment methodology but for which a DRG allowed amount cannot be computed, regardless of whether or not these claim are paid;

H-9.4.2. For treatment encounters subject to the TRICARE per diem payments, negotiated rate, Government-directed rate, or the DRG-reimbursement methodology, the "total amount billed" is the correct per diem, negotiated rate, or DRG-based allowable amount including any applicable outlier amounts.

H-9.5. TED Occurrence Error Determination.

H-9.5.1. The TED occurrence error rate is defined as the total number of errors divided by the total number of data fields in the sample times 100.

H-9.5.2. Occurrence errors determinations are based on only the claim information available and those processing actions taken at the time of adjudication. Actions and determinations occurring subsequent to the processed date of an audited claim, such as obtaining other health insurance documentation, adjusting a claim to correct financial or other data fields, or developing for required information not obtained prior to processing, are not a consideration of the audit regardless of whether a resolution of the incorrectly coded TED results.

H-9.5.3. Occurrence errors result from an incorrect entry in any data field of the TED. There are no exceptions. Any error, including errors in financial fields, shall be counted as occurrence errors.

H-9.5.4. Some TED error conditions are not attributable to any one specific data field but apply to the record as a whole or to certain parts of the record. In addition to erroneous data field coding, the following error conditions involving incorrect or unsupported records will result in occurrence errors being assessed as indicated.

H-9.5.5. The following are occurrence error categories and codes. All TED record occurrence errors, including errors in financial fields, are counted and the error rate is expressed as a percentage of the total number of data fields in the TED record.

Error Conditions Specific to Data Field Categories

- A Incorrect Claim Information
- B Incorrect Patient/Sponsor Information

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C	Incorrect Provider Information
D	Incorrect Admission/Discharge Information (Institutional TED Records only)
E	Incorrect Diagnosis/Treatment Information (Institutional TED Records only)
F	Incorrect Diagnosis Information (Non-Institutional TED Records only)
G	Incorrect Financial Information
H	Incorrect Institutional Revenue Data
I	Incorrect Non-Institutional Claims/Provider/Utilization Data

Error Codes	Error Condition Specific to Claim	Number of Errors
01J	Unlike Procedures/Providers Combined (Noninstitutional Record)	7 errors for each additional utilization data set*
02J	Unlike Revenue Codes Combined (Institutional Record)	5 errors for each erroneous revenue code set**
03J	Services Should Be Combined	1 error for each additional revenue code/utilization data set
04J	Missing Noninstitutional Utilization Data Set	7 errors for each missing data set*
05J	Extra Noninstitutional Utilization Data Set	7 errors for each extra data set*
06J	Missing Institutional Revenue Code Set	5 errors for each missing revenue code set**
07J	Extra Institutional Revenue Code Set	5 errors for each extra revenue code set**
08J	Incorrect Record Type	5 errors
09J	Separate TED Record Required	1 error
10J	Claim Not Provided for Audit	1 error plus 1 error for each revenue code utilization data set in the TED
11J	Claim Not Auditable	1 error plus 1 error for each revenue code utilization data set in the TED
12J	Unsupported TED Transaction	1 error plus 1 error for each revenue code utilization data set in the TED

* Not to exceed 21 errors for combination of these error conditions

** Not to exceed 15 errors for combination of these error conditions

H-9.5.6. The following are payment errors on which post payment actions are either not applicable or would not remove the payment errors assessed.

01K	Authorization/Preauthorization needed (all - except ECHO* and Adjunctive Dental Authorizations)
03K	Billed Amount Incorrect
04K	Cost-share/Deductible Error
07K	Duplicate Services Paid
08K	Eligibility Determination - Patient
09K	Eligibility Determination - Provider
12K	Non-Availability Statement Error
13K	OHI/TPL - Govt. Pay Miscalculated
14K	OHI Payment Omitted
15K	Payee Wrong - Sponsor/Patient
16K	Payee Wrong - Provider
17K	Participating/Non-Participating Error
18K	Pricing Incorrect
19K	Procedure Code Incorrect

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20K	Signature Error
22K	DRG Reimbursement Error
24K	Incorrect Benefit Determination
25K	Claim Not Provided
26K	Claim Not Auditable
27K	Incorrect MCS System

H-9.5.7. The following are payment errors on which post-payment actions may support original processing. On rebuttal, if documentation is provided that supports the processing actions, the payment errors could be removed but the process errors would remain.

01K	Authorization/Pre-Authorization Needed (ECHO* and adjunctive dental authorizations)
02K	Unsupported Benefit Determination
05K	Development Claim Denied Prematurely
06K	Development Required
10K	Medical Emergency Not Substantiated
11K	Medical Necessity/Review Not Evident
21K	Timely Filing Error
23K	Contract Jurisdiction Error
99K	Other - This payment error is very general and claims would have to be reviewed on an individual basis with regard to post-payment actions.

*ECHO Extended Care Health Option

H-9.5.8. The following are process errors which will be assessed for noncompliance of a required procedure/process. These errors are neither occurrence errors nor payment errors and are not used to calculate the occurrence error or payment error rate. A payment error will be assessed along with the process error. Upon rebuttal, if the process is followed to conclusion and the actions support the original decision, the payment error will be removed but the process error will remain.

01P	Authorization/Pre-authorization needed (ECHO and adjunctive dental authorizations)
02P	Unsupported Benefit Determinations
05P	Development Claim Denied Prematurely
06P	Development Required
10P	Medical Emergency Not Substantiated
11P	Medical Necessity/Review Not Evident
21P	Timely Filing Error
23P	Contract Jurisdiction Error
99P	Other

H-9.6. Quarterly Payment and Error Determination Rebuttals. Contractor rebuttals of audit error findings must be submitted to TMA or the designated audit Contractor within 30 calendar days of the date of the audit transmittal letters. Rebuttals not postmarked within 30 calendar days of the audit letter will be excluded from further consideration. Rebuttal responses are final and will not receive further consideration except when during the audit rebuttal process the Contractor submits a claim not previously submitted with the audit and an error is assessed, or when the Contractor's explanation of the basis on which a claim was processed results in the assessment of a new error not previously reviewed by the Contractor. Contractor rebuttals to new errors assessed by TMA or the designated audit Contractor during the initial rebuttal process must be postmarked within 30 calendar days of the TRICARE or designated audit Contractor rebuttal response letter. Rebuttals to new errors not postmarked within 30 calendar days from the date of the rebuttal letter will be excluded from further consideration. The due dates of rebuttals will be

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calculated by adding 30 to the Julian calendar date of the TMA or designated audit Contractor audit letter or by adding 30 to the Julian calendar date of the TMA or designated audit Contractor rebuttal response letter.

H-10. EVOLVING PRACTICES, DEVICES, MEDICINES, TREATMENTS AND PROCEDURES

H-10.1. Medical practices and procedures are expected to continue to evolve during the period of this contract. Some of these changes will increase and some will decrease the cost of medical care. These changes may include practices, devices, medicines, treatments, and procedures that previously were excluded from TRICARE benefits as unproven. The Contractor shall implement moves from unproven to proven as required at no change in contract price. Changes to the requirements caused by changes in the statutory definitions of the benefit or new benefits added by statute will be implemented under the Changes clause.

H-10.2. TRICARE can only cover costs for medically necessary supplies and services. Regulatory procedures are in place at 32 CFR 199.4(g)(15) that describe the procedure for evaluating the safety and efficacy of unproven drugs, devices, medical treatments, or medical procedures. The Contractor shall be responsible for routinely reviewing the hierarchy of reliable evidence, as defined in 32 CFR 199.2.

H-11. INTEGRATED PROCESS TEAMS

H-11.1. The Government may develop major contract and program changes through Integrated Process Teams (IPTs). IPTs will not be formed for all contract changes, but generally will be formed for complex, system-wide issues. The IPT process required in this section begins the date when the Contracting Officer notifies the Contractor in writing. The Contractor will provide the appropriate personnel (as agreed to by the Contracting Officer and the Contractor) to serve on IPTs to develop and/or improve the technical, business, and implementation approach to any proposed TRICARE program contract changes within 14 calendar days after written notification by the Contracting Officer.

H-11.2. The Contractor shall participate in all required meetings as determined by the Government team lead within the change milestones described in this section, regardless of how they are held (in person, via teleconference, by video-teleconference, or through electronic conferences). The frequency and scheduling will vary depending on the topic. The Contractor will participate with the Government team in the entire process from concept development through the final requirement. The IPT process required in this section includes developing the Government's budgetary cost estimates, identifying requirements, developing associated rough order of magnitude cost estimates, and preparing the final specification/statement of work. The IPT process required in this section will end at this point; thus this requirement does not include post-change order activities such as implementation/coordination meetings and definitization efforts, whose costs are allocable to the change.

(End of Section)

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I-1. 52.202-1 DEFINITIONS (JUL 2004)
(Reference 2.201)

I-2. 52.203-3 GRATUITIES (APR 1984)
(Reference 3.202)

I-3. 52.203-5 COVENANT AGAINST CONTINGENT FEES (APR 1984)
(Reference 3.404)

I-4. 52.203-6 RESTRICTIONS ON SUBCONTRACTOR SALES TO THE GOVERNMENT (SEP 2006)
(Reference 3.503-2)

I-5. 52.203-7 ANTI-KICKBACK PROCEDURES (JUL 1995)
(Reference 3.502-3)

I-6. 52.203-8 CANCELLATION, RESCISSION, AND RECOVERY OF FUNDS FOR ILLEGAL OR IMPROPER ACTIVITY (JAN 1997)
(Reference 3.104-9(a))

I-7. 52.203-10 PRICE OR FEE ADJUSTMENT FOR ILLEGAL OR IMPROPER ACTIVITY (JAN 1997)
(Reference 3.104-9(b))

I-8. 52.203-11 CERTIFICATION AND DISCLOSURE REGARDING PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS (SEP 2007)
(Reference 3.808)

I-9. 52.203-12 LIMITATION ON PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS (SEP 2007)
(Reference 3.808(b))

I-10. 52.203-13 CONTRACTOR CODE OF BUSINESS ETHICS AND CONDUCT
(Reference 3.1004(a))

(a) Definitions. As used in this clause— "Agent" means any individual, including a director, an officer, an employee, or an independent Contractor, authorized to act on behalf of the organization. "Full cooperation"—

(1) Means disclosure to the Government of the information sufficient for law enforcement to identify the nature and extent of the offense and the individuals responsible for the conduct. It includes providing timely and complete response to Government auditors' and investigators' request for documents and access to employees with information;

(2) Does not foreclose any Contractor rights arising in law, the FAR, or the terms of the contract. It does not require—

(i) A Contractor to waive its attorney-client privilege or the protections afforded by the attorney work product doctrine; or

(ii) Any officer, director, owner, or employee of the Contractor, including a sole proprietor, to waive his or her attorney client privilege or Fifth Amendment rights; and

(3) Does not restrict a Contractor from—

(i) Conducting an internal investigation; or

(ii) Defending a proceeding or dispute arising under the contract or related to a potential or disclosed violation. "Principal" means an officer, director, owner, partner, or a person having primary management or supervisory responsibilities within a business entity (e.g., general manager; plant manager; head of a subsidiary, division, or business segment; and similar positions).

"Subcontract" means any contract entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract.

"Subcontractor" means any supplier, distributor, vendor, or firm that furnished supplies or services to or for a prime contractor or another subcontractor.

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"United States," means the 50 States, the District of Columbia, and outlying areas.

(b) Code of business ethics and conduct.

(1) Within 30 days after contract award, unless the Contracting Officer establishes a longer time period, the Contractor shall-

(i) Have a written code of business ethics and conduct; and

(ii) Make a copy of the code available to each employee engaged in performance of the contract.

(2) The Contractor shall-

(i) Exercise due diligence to prevent and detect criminal conduct; and

(ii) Otherwise promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law.

(3) (i) The Contractor shall timely disclose, in writing, to the agency Office of the Inspector General (OIG), with a copy to the Contracting Officer, whenever, in connection with the award, performance, or closeout of this contract or any subcontract thereunder, the Contractor has credible evidence that a principal, employee, agent, or subcontractor of the Contractor has committed-

(A) A violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 of the United States Code; or
(B) A violation of the civil False Claims Act (31U.S.C. 3729-3733).

(ii) The Government, to the extent permitted by law and regulation, will safeguard and treat information obtained pursuant to the Contractor's disclosure as confidential where the information has been marked "confidential" or "proprietary" by the company. To the extent permitted by law and regulation, such information will not be released by the Government to the public pursuant to a Freedom of Information Act request, 5 U.S.C. Section 552, without prior notification to the Contractor. The Government may transfer documents provided by the Contractor to any department or agency within the Executive Branch if the information relates to matters within the organization's jurisdiction.

(iii) If the violation relates to an order against a Governmentwide acquisition contract, a multi-agency contract, a multiple-award schedule contract such as the Federal Supply Schedule, or any other procurement instrument intended for use by multiple agencies, the Contractor shall notify the OIG FAC 2005-28 DECEMBER 12, 2008

I-11. 52.203-14 DISPLAY OF HOTLINE POSTER(S). (DEC 2007)

(Reference 3.1004(b))

(a) Definition.

"United States," as used in this clause, means the 50 States, the District of Columbia, and outlying areas.

(b) Display of fraud hotline poster(s). Except as provided in paragraph (c) -

(1) During contract performance in the United States, the Contractor shall prominently display in common work areas within business segments performing work under this contract and at contract work sites -

(i) Any agency fraud hotline poster or Department of Homeland Security (DHS) fraud hotline poster identified in paragraph (b) (3) of this clause; and

(ii) Any DHS fraud hotline poster subsequently identified by the Contracting Officer.

(2) Additionally, if the Contractor maintains a company website as a method of providing information to employees, the Contractor shall display an electronic version of the poster(s) at the website.

(3) Any required posters may be obtained as follows:

Poster(s)

Obtain from

Department of Defense

Defense Hotline

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Hotline for Reporting Fraud, Waste, and Abuse The Pentagon
Washington, D.C.
20301-1900
Email: hotline@dodig.osd.mil (800) 424-9098

Hotline Department of Defense
The Pentagon
Washington, D.C.
20301-1900
Email: hotline@dodig.osd.mil (800) 424-9098

(c) If the Contractor has implemented a business ethics and conduct awareness program, including a reporting mechanism, such as a hotline poster, then the Contractor need not display any agency fraud hotline posters as required in paragraph (b) of this clause, other than any required DHS posters.

(d) Subcontracts. The Contractor shall include the substance of this clause, including this paragraph (d), in all subcontracts that exceed \$5,000,000, except when the subcontract -

- (1) Is for the acquisition of a commercial item; or
- (2) Is performed entirely outside the United States.

(End of Clause)

I-12. 52.204-4 PRINTED OR COPIED DOUBLE-SIDED ON RECYCLED PAPER (AUG 2000)
(Reference 4.303)

I-13. 52.204-7 CENTRAL CONTRACTOR REGISTRATION (APR 2008)
(Reference 4.1104)

I-14. 52.204-9 PERSONAL IDENTITY VERIFICATION OF CONTRACTOR PERSONNEL (SEP 2007)
(Reference 4.1301)

I-15. 52.204-10 REPORTING SUBCONTRACT AWARDS (SEP 2007)
(Reference 4.1401(a))

(a) Definition. Subcontract, as used in this clause, means any contract as defined in FAR Subpart 2.1 entered into by the Contractor to furnish supplies or services for performance of this contract. It includes, but is not limited to, Purchase orders and changes and modifications to purchases orders, but does not include contracts that provide supplies or services benefiting two or more contracts.

(b) Section 2(d) of the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. No. 109-282) requires establishment of a pilot program for a single searchable website, available to the public at no charge that includes information on Federal subcontracts.

(c) Within thirty days after the end of March, June, September, and December of each year through 2008, the Contractor shall report the following information at www.esrs.gov for each subcontract award with a value greater than \$1 million made during that quarter. (The Contractor shall follow the instructions at www.esrs.gov to report the data.)

- (1) Name of the subcontractor.
- (2) Amount of the award.
- (3) Date of award.
- (4) The applicable North American Industry Classification System code.
- (5) Funding agency or agencies.
- (6) Award title descriptive of the purpose of the action.
- (7) Contract number.
- (8) Subcontractor location including address.
- (9) Subcontract primary performance location including address.
- (10) Unique identifier for the subcontractor.

(End of Clause)

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I-16. 52.209-6 PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED, OR PROPOSED FOR DEBARMENT (SEP 2006)
(Reference 9.409(b))

I-17. 52.211-15 DEFENSE PRIORITY AND ALLOCATION REQUIREMENTS (APR 2008)
(Reference 11.604(b))

I-18. 52.215-2 AUDIT AND RECORDS - NEGOTIATION (MAR 2009)
(Reference 15.209(b)(1))

I-19. 52.215-8 ORDER OF PRECEDENCE - UNIFORM CONTRACT FORMAT (OCT 1997)
(Reference 15.209(h))

I-20. 52.215-11 PRICE REDUCTION FOR DEFECTIVE COST OR PRICING DATA - MODIFICATIONS (Oct 1997)
(Reference 15.408(c))

I-21. 52.215-13 SUBCONTRACTOR COST OR PRICING DATA - MODIFICATIONS (Oct 1997)
(Reference 15.408(e))

I-22. 52.215-17 WAIVER OF FACILITIES CAPITAL COST OF MONEY (OCT 1997)
(Reference 15.408(i))

I-23. 52.215-18 REVERSION OR ADJUSTMENT OF PLANS FOR POSTRETIREMENT BENEFITS (PRB) OTHER THAN PENSIONS (JUL 2005)
(Reference 15.408(j))

I-24. 52.215-19 NOTIFICATION OF OWNERSHIP CHANGES (OCT 1997)
(Reference 15.408(k))

I-25. 52.215-21 REQUIREMENTS FOR COST OR PRICING DATA OR INFORMATION OTHER THAN COST OR PRICING DATA - MODIFICATION (OCT 1997), ALTERNATE III (OCT 1997)
(Reference 15.408(m))

I-26. 52.216-7 ALLOWABLE COST AND PAYMENT (DEC 2002)
(Reference 16.307(a))

I-27. 52.216-8 FIXED FEE (MAR 1997)
(Reference 16.307(b))

I-28. 52.216-26 PAYMENTS OF ALLOWABLE COSTS BEFORE DEFINITIZATION (DEC 2002)
(Reference 16.603-4(c))

I-29. 52.217-8 OPTION TO EXTEND SERVICES (NOV 1999)
(Reference 17.208(f))

I-30. 52.217-9 OPTION TO EXTEND THE TERM OF THE CONTRACT (MAR 2000)
(Reference 17.208(g))

I-31. 52.219-4 NOTICE OF PRICE EVALUATION PREFERENCE FOR HUBZONE SMALL BUSINESS CONCERNS (JUL 2005)
(Reference 19.1308(b))

I-32. 52.219-8 UTILIZATION OF SMALL BUSINESS CONCERNS (MAY 2004)
(Reference 19.708(a))

I-33. 52.219-9 SMALL BUSINESS SUBCONTRACTING PLAN (APR 2008), ALTERNATE II, (OCT 2001)
(Reference 19.708(b))

I-34. 52.219-16 LIQUIDATED DAMAGES - SUBCONTRACTING PLAN (JAN 1999)

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(Reference 19.708 (b) (2))

I-35. 52.222-1 NOTICE TO THE GOVERNMENT OF LABOR DISPUTES (FEB 1997)
(Reference 22.103-5(a))

I-36. 52.222-3 CONVICT LABOR (JUN 2003)
(Reference 22.202)

I-37. 52.222-21 PROHIBITION OF SEGREGATED FACILITIES (FEB 1999)
(Reference 22.810(a) (1))

I-38. 52.222-26 EQUAL OPPORTUNITY (MAR 2007)
(Reference 22.810(e))

I-39. 52.222-35 EQUAL OPPORTUNITY FOR SPECIAL DISABLED VETERANS, VETERANS OF THE VIETNAM ERA, AND OTHER ELIGIBLE VETERAN (SEP 2006), ALTERNATE I (DEC 2001)
(Reference 22.1310(A) (1))

I-40. 52.222-36 AFFIRMATIVE ACTION FOR WORKERS WITH DISABILITIES (JUN 1998), ALTERNATE I (SEP 2006)
(Reference 22.1408(a))

I-41. 52.222-39 NOTIFICATION OF EMPLOYEE RIGHTS CONCERNING PAYMENT OF UNION DUES OR FEES (DEC 2004)
(Reference 22.1605)

(a) Definition: As used in this clause - "United States" means the 50 States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, and Wake Island.

(b) Except as provided in paragraph (e) of this clause, during the term of this contract, the Contractor shall post a notice, in the form of a poster, informing employees of their rights concerning union membership and payment of union dues and fees, in conspicuous places in and about all its plants and offices, including all places where notices to employees are customarily posted. The notice shall include the following information (except that the information pertaining to National Labor Relations Board shall not be included in notices posted in the plants or offices of carriers subject to the Railway Labor Act, as amended (45 U.S.C. 151-188)).

Notice to Employees

Under Federal law, employees cannot be required to join a union or maintain membership in a union in order to retain their jobs. Under certain conditions, the law permits a union and an employee to enter into a union-security agreement requiring employees to pay uniform periodic dues and initiation fees. However, employees who are not union members can object to the use of their payments for certain purposes and can only be required to pay their share of union costs relating to collective bargaining, contract administration, and grievance adjustment.

If you do not want to pay that portion of dues or fees used to support activities not related to collective bargaining, contract administration, or grievance adjustment, you are entitled to an appropriate reduction in your payment. If you believe that you have been required to pay dues or fees used in part to support activities not related to collective bargaining, contract administration, or grievance adjustment, you may be entitled to a refund and to an appropriate reduction in future payments.

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For further information concerning your rights, you may wish to contact the National Labor Relations Board (NLRB) either at one of its Regional offices or at the following address or toll free number:

National Labor Relations Board
Division of Information
1099 14th Street, N.W.
Washington, DC 20570
1-866-667-6572
1-866-316-6572 (TTY)

To locate the nearest NLRB office, see NLRB's website at <http://www.nlr.gov>.

(c) The Contractor shall comply with all provisions of Executive Order 13201 of February 17, 2001, and related implementing regulations at 29 CFR Part 470, and orders of the Secretary of Labor.

(d) In the event that the Contractor does not comply with any of the requirements set forth in paragraphs (b), (c), or (g), the Secretary may direct that this contract be cancelled, terminated, or suspended in whole or in part, and declare the Contractor ineligible for further Government contracts in accordance with procedures at 29 CFR Part 470, Subpart B - Compliance Evaluations, Complaint Investigations and Enforcement Procedures. Such other sanctions or remedies may be imposed as are provided by 29 CFR Part 470, which implements Executive Order 13201, or as are otherwise provided by law.

(e) The requirement to post the employee notice in paragraph (b) does not apply to -

(1) Contractors and subcontractors that employ fewer than 15 persons;
(2) Contractor establishments or construction work sites where no union has been formally recognized by the Contractor or certified as the exclusive bargaining representative of the Contractor's employees;

(3) Contractor establishments or construction work sites located in a jurisdiction named in the definition of the United States in which the law of that jurisdiction forbids enforcement of union-security agreements;

(4) Contractor facilities where upon the written request of the Contractor, the Department of Labor Deputy Assistant Secretary for Labor-Management Programs has waived the posting requirements with respect to any of the Contractor's facilities if the Deputy Assistant Secretary finds that the Contractor has demonstrated that -

(i) The facility is in all respects separate and distinct from activities of the Contractor related to the performance of a contract; and

(ii) Such a waiver will not interfere with or impede the effectuation of the Executive order; or

(5) Work outside the United States that does not involve the recruitment or employment of workers within the United States.

(f) The Department of Labor publishes the official employee notice in two variations; one for Contractors covered by the Railway Labor Act and a second for all other Contractors. The Contractor shall -

(1) Obtain the required employee notice poster from the Division of Interpretations and Standards, Office of Labor-Management Standards, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-5605, Washington, DC 20210, or from any field office of the Department's Office of Labor-Management Standards or Office of Federal Contract Compliance Programs;

(2) Download a copy of the poster from the Office of Labor-Management Standards website at <http://www.olms.dol.gov>; or

(3) Reproduce and use exact duplicate copies of the Department of Labor's official poster.

(g) The Contractor shall include the substance of this clause in every subcontract or purchase order that exceeds the simplified acquisition threshold, entered into in connection with this contract, unless exempted by the Department

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of Labor Deputy Assistant Secretary for Labor-Management Programs on account of special circumstances in the national interest under authority of 29 CFR 470.3(c). For indefinite quantity subcontracts, the Contractor shall include the substance of this clause if the value of orders in any calendar year of the subcontract is expected to exceed the simplified acquisition threshold. Pursuant to 29 CFR Part 470, Subpart B - Compliance Evaluations, Complaint Investigations and Enforcement Procedures, the Secretary of Labor may direct the Contractor to take such action in the enforcement of these regulations, including the imposition of sanctions for non-compliance with respect to any such subcontract or purchase order. If the Contractor becomes involved in litigation with a subcontractor or vendor, or is threatened with such involvement, as a result of such direction, the Contractor may request the United States, through the Secretary of Labor, to enter into such litigation to protect the interests of the United States.

(End of Clause)

I-42. 52.222-41 SERVICE CONTRACT ACT OF 1965 (NOV 2007)
(Reference 22.1006(a))

I-43. 52.222-42 STATEMENT OF EQUIVALENT RATES FOR FEDERAL HIRES (MAY 1989)

I-44. 52-222-43 FAIR LABOR STANDARDS ACT AND SERVICE CONTRACT ACT

I-45. 52.222-50 COMBATING TRAFFICKING IN PERSONS (FEB 2009)
(Reference 22.1705(a))

I-46. 52.223-6 DRUG-FREE WORKPLACE (MAY 2001)
(Reference 23.505)

I-47. 52.224-1 PRIVACY ACT NOTIFICATION (APR 1984)
(Reference 24.104(a))

I-48. 52.224-2 PRIVACY ACT (APR 1984)
(Reference 24.104(b))

I-49. 52.225-13 RESTRICTIONS ON CERTAIN FOREIGN PURCHASES (JUN 2008)
(Reference 25.1103(a))

I-50. 52.227-1 AUTHORIZATION AND CONSENT (JUL 1995)
(Reference 27.201-2(a))

I-51. 52.227-3 PATENT INDEMNITY (APR 1984)
(Reference 27.203-1(b), 27.203-2(a), 27.203-4(a)(2))

I-52. 52.227-14 RIGHTS IN DATA - GENERAL (DEC 2007)
(Reference 27.409(a)(1))

I-53. 52.228-3 WORKERS' COMPENSATION INSURANCE (DEFENSE BASE ACT) (APR 1984)
(Reference 28.309(a))

WORKERS' COMPENSATION INSURANCE(DEFENSE BASE ACT) (APR 1984)

The Contractor shall (a) provide, before commencing performance under this contract, such workers' compensation insurance or security as the Defense Base Act(42 U.S.C. 1651, et seq.) requires and (b) continue to maintain it until performance is completed. The Contractor shall insert, in all subcontracts under this contract to which the Defense Base Act applies, a clause similar to this clause (including this sentence) imposing upon those subcontractors requirement to comply with the Defense Base Act.

(End of Clause)

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- I-54. 52.228-7 INSURANCE - LIABILITY TO THIRD PERSONS (MAR 1996)
(Reference 28.311-1)
- I-55. 52.229-3 FEDERAL, STATE, AND LOCAL TAXES (APR 2003)
(Reference 29.401-3)
- I-56. 52.230-2 COST ACCOUNTING STANDARDS (OCT 2008)
(Reference 30.201-4(a))
- I-57. 52.230-6 ADMINISTRATION OF COST ACCOUNTING STANDARDS (MAR 2008)
(Reference 30.201-4(d))
- I-58. 52.232-1 PAYMENTS (APR 1984)
(Reference 32.111(a)(1))
- I-59. 52.232-8 DISCOUNTS FOR PROMPT PAYMENT (FEB 2002)
(Reference 32.111(b)(1))
- I-60. 52.232-9 LIMITATION ON WITHHOLDING OF PAYMENTS (APR 1984)
(Reference 32.111(b)(2))
- I-61. 52.232-11 EXTRAS (APR 1984)
(Reference 32.111(c)(2))
- I-62. 52.232-17 INTEREST (OCT 2008)
(Reference 32.617(a) and (b))
- I-63. 52.232-18 AVAILABILITY OF FUNDS (APR 1984)
(Reference 32.708-1(a))
- I-64. 52.232-23 ASSIGNMENT OF CLAIMS (JAN 1986)
(Reference 32.806(a)(1))
- I-65. 52.232-25 PROMPT PAYMENT (OCT 2008), ALTERNATE I (FEB 2002)
(Reference 32.908(c)(3))
- I-66. 52.232-33 PAYMENT BY ELECTRONIC FUNDS TRANSFER - CENTRAL CONTRACTOR
REGISTRATION (OCT 2003)
(Reference 32.1110(a), (a)(1), (b) and (e)(1))
- I-67. 52.233-1 DISPUTES (JUL 2002), ALTERNATE I (DEC 1991)
(Reference 33.215)
- I-68. 52.233-3 PROTEST AFTER AWARD (AUG 1996), ALTERNATE I (JUN 1985)
(Reference 33.106(b))
- I-69. 52.233-4 APPLICABLE LAW FOR BREACH OF CONTRACT CLAIM (OCT 2004)
(Reference 33.215(b))
- I-70. 52.237-3 CONTINUITY OF SERVICES (JAN 1991)
(Reference 37.110(c))
- I-71. 52.242-1 NOTICE OF INTENT TO DISALLOW COSTS (APR 1984)
(Reference 42.802)
- I-72. 52.242-13 BANKRUPTCY (JUL 1995)
(Reference 42.903)
- I-73. 52.243-1 CHANGES - FIXED PRICE (AUG 1987), ALTERNATE I (APR 1984)
(Reference 43.205(a)(2))

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- I-74. 52.243-7 NOTIFICATION OF CHANGES (APR 1984)
(Reference 43.107)
- I-75. 52.244-2 SUBCONTRACTS (JUN 2007)
(Reference 44.204 (a) (1))
- I-76. 52.244-5 COMPETITION IN SUBCONTRACTING (DEC 1996)
(Reference 44.204 (c))
- I-77. 52.244-6 SUBCONTRACTS FOR COMMERCIAL ITEMS (MAY 2009)
(Reference 44.403)
- I-78. 52.245-1 GOVERNMENT PROPERTY (JUNE 2007)
(Reference 45.107 (a))
- I-79. 52.246-20 WARRANTY OF SERVICES (MAY 2001)
(Reference 46.710 (d))
- I-80. 25.246-25 LIMITATION OF LIABILITY - SERVICES (FEB 1997)
(Reference 46.8050 (a) (4))
- I-81. 52.249-2 TERMINATION FOR CONVENIENCE OF THE GOVERNMENT (FIXED-PRICE) (MAY 2004)
(Reference 49.502 (b) (1) (i))
- I-82. 52.249-8 DEFAULT (FIXED-PRICE SUPPLY AND SERVICE) (APR 1984)
(Reference 49.504 (a) (1))
- I-83. 52.249-14 EXCUSABLE DELAYS (APR 1984)
(Reference 49.505 (d))
- I-84. 52.251-1 GOVERNMENT SUPPLY SOURCES (APR 1984)
(Reference 51.107)
- I-85. 252.201-7000 CONTRACTING OFFICER'S REPRESENTATIVE (DEC 1991)
(Reference 201.602-70)

(a) Definition: "Contracting Officer's Representative" means an individual designated in accordance with subsection 201.602-2 of the Defense Federal Acquisition Regulation Supplement and authorized in writing by the contracting officer to perform specific technical or administrative functions.

(b) If the Contracting Officer designates a contracting officer's representative (COR), the Contractor will receive a copy of the written designation. It will specify the extent of the COR's authority to act on behalf of the contracting officer. The COR is not authorized to make any commitments or changes that will affect price, quality, quantity, delivery, or any other term or condition of the contract.

(End of Clause)

- I-86. 252.203-7001 PROHIBITION ON PERSONS CONVICTED OF FRAUD OR OTHER DEFENSE-CONTRACT-RELATED FELONIES (DEC 2008)
(Reference 203.570-3)
- I-87. 252.203-7002 DISPLAY OF DOD HOTLINE POSTER (JAN 2009)
(Reference 203.7002)
- I-88. 252.204-7000 DISCLOSURE OF INFORMATION (DEC 1991)
(Reference 204.404-70 (a))
- I-89. 252.215-7000 PRICE ADJUSTMENTS (DEC 1991)

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(Reference 215.408(1))

I-90. 252.217-7027 CONTRACT DEFINITIZATION (OCT 1998)
(Reference 217.7406(b))

I-91. 252.219-7003 SMALL, SMALL DISADVANTAGED AND WOMAN-OWNED SMALL BUSINESS
(APR 2007)
(Reference 219.708(b)(1)(a))

I-92. 252.222-7000 RESTRICTIONS ON EMPLOYMENT OF PERSONNEL (MAR 2000)
(Reference 222.7004)

RESTRICTIONS ON EMPLOYMENT OF PERSONNEL (MAR 2000)

(a) The Contractor shall employ, for the purpose of performing that portion of the contract work in Puerto Rico, individuals who are residents thereof and who, in the case of any craft or trade, possess or would be able to acquire promptly the necessary skills to perform the contract.

(b) The Contractor shall insert the substance of this clause, including this paragraph (b), in each subcontract awarded under this contract.

(End of clause)

I-93. 252.231-7000 SUPPLEMENTAL COST PRINCIPLES (DEC 1991)
(Reference 231.100-70)

I-94. 252.232-7008 ASSIGNMENT OF CLAIMS (OVERSEAS) (JUNE 1997)
(Reference 232.806(a)(1))

I-95. 252.232-7010 LEVIES ON CONTRACT PAYMENTS (DEC 2006)
(Reference 232.7102)

(a) 26 U.S.C. 6331(h) authorizes the Internal Revenue Service (IRS) to continuously levy up to 100 percent of contract payments, up to the amount of tax debt.

(b) When a levy is imposed on a payment under this contract and the Contractor believes that the levy may result in an inability to perform the contract, the Contractor shall promptly notify the Procuring Contracting Officer in writing, with a copy to the Administrative Contracting Officer, and shall provide-

(1) The total dollar amount of the levy;

(2) A statement that the Contractor believes that the levy may result in an inability to perform the contract, including rationale and adequate supporting documentation; and

(3) Advice as to whether the inability to perform may adversely affect national security, including rationale and adequate supporting documentation.

(c) DoD shall promptly review the Contractor's assessment, and the Procuring Contracting Officer shall provide a written notification to the Contractor including-

(1) A statement as to whether DoD agrees that the levy may result in an inability to perform the contract; and

(2) (i) If the levy may result in an inability to perform the contract and the lack of performance will adversely affect national security, the total amount of the monies collected that should be returned to the Contractor; or

(ii) If the levy may result in an inability to perform the contract but will not impact national security, a recommendation that the Contractor promptly notify the IRS to attempt to resolve the tax situation.

(d) Any DoD determination under this clause is not subject to appeal under the Contract Disputes Act.

I-96. 252.233-7001 CHOICE OF LAW (OVERSEAS) (JUNE 1997)
(Reference 233.215-70)

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SECTION I
CONTRACT CLAUSES

I-97. 252.243-7001 PRICING OF CONTRACT MODIFICATIONS (DEC 1991)
(Reference 243.205-70)

I-98. 252.243-7002 REQUESTS FOR EQUITABLE ADJUSTMENT (MAR 1998)
(Reference 243.205-71)

I-99. 252.249-7000 SPECIAL TERMINATION COSTS (DEC 1991)
(Reference 249.501-70)

I-100. 52.222-54 EMPLOYMENT ELIGIBILITY VERIFICATION (JAN 2009)
(Reference 22.1803)

I-101. 52.243-6 CHANGE ORDER ACCOUNTING (APR 1984)
(Reference 43.205(f))

(End of Section)

SECTION J
LIST OF ATTACHMENTS

- J-1. Subcontracting Plan
- J-2. TOP Prime Locations
- J-3. TOP Prime Remote Locations
- J-4. Regional Patient Movement Procedures
- J-5. TRICARE Prime Enrollment Application and PCM Change Form
- J-6. TRICARE Prime Disenrollment Application Form
- J-7. Guarantee Agreement for Corporate Guarantor
- J-8. Contract Data Requirements List (CDRL) DD 1423-1
- J-9. TRICARE Service Center (TSC) Government-Furnished Equipment/Workload

(End of Section)