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| **REQUEST FOR PROPOSAL (“RFP”) FOR**    **HEALTH MAINTENANCE ORGANIZATION (HMO) and/or EXCLUSIVE PROVIDER ORGANIZATION SERVICES (EPO) – INCLUDING PRESCRIPTION DRUG REQUIREMENTS FOR CITY OF CHICAGO ONLY**  Required for use by:  **the *City of Chicago*, the *Chicago Park District*, and the *Chicago Public Schools***  **(the “Agencies”)**    This RFP distributed by:  **CITY OF CHICAGO**  **Department of Finance**  All communications must be by Email only, sent to: [HMO-RFP@cityofchicago.org](mailto:HMO-RFP@cityofchicago.org)  **SPECIFICATION No.: 131782**  **PROPOSALS MUST BE RECEIVED NO LATER THAN 4:00 P.M., CENTRAL TIME, ON Tuesday, June 16, 2015**  (or otherwise as may be changed per Addendum)   |  |  | | --- | --- | | **RAHM EMANUEL**  **MAYOR** |  | |

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**ATTACHMENT I**: Non-Disclosure and Confidentiality Agreement Concerning Census and Claims Data CD concerning the Request for Proposal (RFP)

<<End of Exhibits>>

**REQUEST FOR PROPOSAL (“RFP”)**

**for**

**HEALTH MAINTENANCE ORGANIZATION (HMO) and/or EXCLUSIVE PROVIDER ORGANIZATION SERVICES (EPO) – INCLUDING PRESCRIPTION DRUG REQUIREMENTS FOR CITY OF CHICAGO ONLY**

**Background**

The City of Chicago (COC), Chicago Park District (CPD), and Chicago Public Schools (CPS) (collectively, the “Agencies”) each require an HMO health care benefits plan for their group of eligible employees, retirees, and dependents. These three Chicago Agencies have collaborated on issuing this RFP in an attempt to elicit better pricing and realize a more standardized approach towards the management of their HMO plans. Although the terms and conditions of each Agency’s plan (“COC Plan;” “CPD Plan;” and “CPS Plan”), currently meet each Agency’s HMO health care benefits plan requirements on an individual Agency basis, it is through the consolidated effort among these three Agencies working in cooperation with the selected proposer whereby best practices through economies of scale hopes to produce a positive uplift for all parties involved.

**I. GENERAL INVITATION**

**1.1 Purpose of the Request for Proposal**

The Agencies, acting through the COC’s Department of Finance, invites the submission of proposals for a Health Maintenance Organization (HMO) and/or Exclusive Provider Organization Services (EPO)**.** Additionally, for the COC only, the RFP is soliciting proposals for a Prescription Drug solution.

The contract term is targeted for a January 1, 2016 effective date for all of the Agencies. Although the conditions of the RFP allows for one Contractor to be awarded a contract to provide services to all three Agencies, the Agencies may also negotiate separate contracts in accordance with their own interests. Therefore, multiple contracts may be awarded pursuant to this RFP process.

Furthermore, insofar as a company may propose an offer solely for the COC’s Prescription Drug requirements, separate from an HMO Plan offering, such responses may be evaluated on the merits of that proposal, and be considered for award as such.

Organization(s) with demonstrated experience in the area of HMO Plans and/or Prescription Drug solutions, and with an interest in making their services available to the Agencies, are invited to respond to this RFP.

**“Respondent”** means the organization that submits a proposal in response to this RFP. The documents submitted will be referred to as "**Proposals**."

The selected Respondent awarded a contract pursuant to this RFP **(“Selected Respondent” or “Contractor”**) shall perform all applicable duties as outlined in the Scope of Services. The Respondent may have service arrangements and/or alliances with multiple organizations to deliver all required services, however, Respondent’s organization must be the sole business entity for contracting purposes for communication and education, recordkeeping and administration and on-site participant support services.

The work contemplated is professional in nature. It is understood that the Selected Respondent acting as an individual, partnership, corporation, or other legal entity, is of professional status, licensed to perform in the State of Illinois and the COC for all applicable professional discipline(s) requiring licensing and will be governed by the professional ethics in its relationship to the City. It is also understood that all reports, information, or data prepared or assembled by the Selected Respondent under a contract awarded pursuant to this RFP (“**Agreement**”) may be made available to any individual organization, under the Freedom of Information Act (FOIA).

A sample of a standard COC professional services agreement is attached to this RFP as Exhibit VII-A. The Selected Respondent shall be financially solvent and each of its members if a joint venture, its employees, agents, or sub-consultants of any tier shall be competent to perform the services required under this RFP document.

**1.2 Obtaining the RFP Documents**

The RFP and related Exhibits, as well as addenda and/or clarifications if any, can be downloaded at the City’s Department of Finance website at the following URL:

<http://www.cityofchicago.org/city/en/depts/fin.html> under the heading in the center panel: “Most Recent News (Finance),” from where you can access the link to the RFP, and related docs, except for confidential census data and claims data (Exhibits VIII and XIII) which shall be provided on a CD. The CD will only be provided upon receipt of a signed confidentiality and non-disclosure affidavit (see ATTACHMENT I) signed by an authorized representative of the Respondent. The affidavit must be signed and submitted along with identification, in exchange for a copy of the CD from City Hall, 121 North LaSalle Street, Chicago 60602, Room 700, between the hours of 9:30 AM to 4:00 PM, Monday through Friday.

The RFP is composed of various e-files available at the above URL. Exhibits that are not embedded within the main RFP document file are “<< attached by reference >>” and are available as a separate file (mostly PDFs) and are also available at the URL. (Sequential numbers marked “Reserved” have been intentionally omitted.)

The City accepts no responsibility for the timely delivery of materials or for alerting the Respondent on posting information related to this RFP onto the above URL. Under no circumstances shall failure to obtain the RFP, clarifications, and/or any related addenda, if any, relieve a Respondent from being bound by any additional information, terms, and conditions in a clarification or addendum contained therein, during the RFP process. Furthermore, failure to obtain any clarification and/or addendum shall not be valid grounds for a protest against award(s) made under this RFP.

**1.3 Communications via Email Only**

Unless as may otherwise be provided, Respondents must communicate in writing only, at the following email address: [HMO-RFP@cityofchicago.org](mailto:HMO-RFP@cityofchicago.org)

There is a 25 Mb size limit per email. If Respondents send a zipped-file, the City’s security system may route it as a threat and it may not be received. Respondent may request an email receipt as confirmation that your email was received, if such functionality is supported.

There must be no other communication with respect to this solicitation and this RFP process, in person, in writing (except via the email address above), by phone, or otherwise, between a Respondent or Respondent’s designee and any of the Agencies’ member or member’s office staff, any consultant or associate of any consulting group who may be working for an Agency, City elected officials or their staff members, or any other person in a position to influence the decision of the recommendation to award a contract, at any time during the RFP process, except at times specified for oral presentations of selected Respondents or as may otherwise expressly be provided for during this RFP process.

Communication by a Respondent or its designee with anyone who falls within the title or role described in this section, in an attempt to influence the awarding of the RFP, shall be considered grounds for the Respondent to be disqualified. A Respondent who deviates from any of these restrictions is subject to immediate disqualification from this RFP process.

**1.4 Questions and/or Requests for Clarification**

Any question or request for clarification concerning this RFP must be made in writing and sent to the email address above (Section 1.3), in the format as exampled below, using an Excel spreadsheet.

**Example 1**

|  |  |  |
| --- | --- | --- |
| **ITEM** | **QUESTION or**  **REQUEST for CLARIFICATION** | **RFP section being referenced** |
| 1 | What is a DAW code? | Definitions |
| 2 | What are PPACA requirements | Exhibit 10; Item #13 |

The COC, on behalf of and in consultation with the appropriate Agency, will provide its response to all questions and requests for clarifications received via an addendum. (See Addenda section 1.6 below.)

Any subsequent round of questions or requests for clarification, if allowed by the Agencies, shall be subject to a cut-off date and time and be posted at the URL and related links indicated above in section 1.2.

**1.5 Pre-Proposal Conference**

The Agencies will NOT conduct a Pre-Proposal Conference for this RFP.

**1.6 Addenda and RFP Notices**

The COC shall post all addenda and related RFP notices, if any, at the URL and related links indicated above in Section 1.2.

**1.7 Proposal Delivery Information**

Proposals must be provided as a hardcopy printed document, as well as electronically on a thumb-drive.

Proposal hardcopies must be delivered no later than 4:00 p.m. Chicago-time at the address indicated below, on the due date as posted in the RFP or, in the latest due date posted at the URL and related links indicated above in section 1.2.

All hardcopy Proposal packages must be labeled as follows:

**HMO-RFP Specification No. 131782**

**ATTN: Steve Sakai**

**Respondent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Due Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

All hardcopy Proposal packages and thumb-drives must be delivered to the front reception desk located at:

**Department of Finance**

**City Hall – 7th Floor**

**121 N. LaSalle Street**

**Chicago IL 60602-1246**

All Proposal submittals are due by 4:00 p.m., **Tuesday, June 16, 2015**;or on the most recent due date posted at the URL and related links indicated above in section 1.2.

Proposals that are not received by the date and time as posted may not be accepted.

Respondent must submit its Proposal hardcopies and thumb-drives as follows:

* 1 hardcopy ORIGINAL of the Proposal, clearly marked as “PROPOSAL ORIGINAL”.
  + The original Proposal must bear the original signature of an authorized corporate agent on all documents requiring a signature
* 20 hardcopy COPIES of the exact copy of the original Proposal
  + plus one thumb-drive per Proposal copy (x10)
    - each thumb-drive should be marked “Proposal”
    - each thumb-drive must be an exact copy of the original hardcopy Proposal
    - each thumb-drive file must be word searchable

**1.8 RFP – Contract Award Estimated Timeline**

The timeline for this RFP process is summarized below. Note that these are target dates and are subject to change by the Agencies.

|  |  |  |
| --- | --- | --- |
| **Key Activity** | **Target Date** | **# days bt date above** |
| City Issues RFP | Friday, May 15, 2015 | 0 |
| Submit Questions by | Wednesday, May 20, 2015 | 5 |
| Answers to Questions Posted by | Friday, May 22, 2015 | 2 |
| Proposals Due on | Tuesday, June 16, 2015 | 25 |
| Agency Review and Evaluations | Friday, June 26, 2015 | 10 |
| Finalist Presentations | Monday, June 29, 2015 | 3 |
| Selection of Contractor(s) | Wednesday, July 15, 2015 | 16 |
| Recommendation of Award | Thursday, July 16, 2015 | 1 |
| Execution of Contract Agreement | Monday, December 21, 2015 | 158 |
| Effective Date of Agreement | Friday, January 01, 2016 | 11 |
| Implementation Start Date | Monday, January 04, 2016 | 3 |

**II. SCOPE OF SERVICES**

**A. Scope of Services**

Notwithstanding any other requirement that may be required by an Agency pursuant to this RFP, the Agencies seek to acquire (the “Services”) as derived from, but not limited to, the Proposal responses received through this RFP process, including responses to Exhibit XVI Interrogatives and any other related information. Generally, Respondents must provide:

1. Healthcare benefits to qualified Agency employees, retirees, and their eligible dependents
2. Prescription Drug management services for the City of Chicago only
3. Hosted website service access to support the Agency and Subscriber requirements
4. Customer Service Representatives to provide Subscriber help services
5. Provider Service management
6. Primary-care Physician management services
7. Communication Services of information to Subscribers

**B. Term of Services**

The initial contract base term period will be **three (3)** years from the date on which a contract is awarded by the Agencies, unless, however, an Agency – individually – awards its contract to its Selected Respondent separately from the other Agencies. In addition, the contract shall provide that the Agency may elect to extend the contract, in the Agency’s discretion, for up to two (2) additional periods, each period not to exceed one year, and, notwithstanding any other extension authorizations, continue to provide ongoing services until such time a new service provider contract is executed.

**III. PREPARING PROPOSALS: REQUIRED INFORMATION**

Each Proposal must contain all of the following documents and must conform to the following requirements.

**A. Format of Proposal**

**Hardcopies.** The original Proposal and all copies of the original Proposalshould be prepared on “8½ x 11” letter size paper (preferably recycled), printed double-sided and bound on the long side. The City encourages using reusable, recycled, recyclable and chlorine-free printed materials for bids, proposals, reports, and other documents prepared in connection with this solicitation. Expensive papers and bindings are discouraged, as no materials will be returned.

Sections should be separated by labeled tabs and organized in accordance with subject matter sequence as set forth below.

**Electronic Copies.** Electronic copies of Proposal responses must be provided on thumb-drives and must display pages in the same sequence as the hardcopy originals and facilitate Word-Searchable functionality on the provided file copies. Financial statements may be provided electronically only.

**B. Confidentiality**

Respondent may designate those portions of the Proposal, which contain trade secrets or other proprietary data that must remain confidential. If a Respondent includes data that is not to be disclosed to the public for any purpose or used by the Agencies except for evaluation purposes, the Respondent must:

1. Mark the title page as follows: “This RFP proposal includes trade secrets or other proprietary data (“data”) that may not be disclosed outside the Agencies and may not be duplicated, used or disclosed in whole or in part for any purpose other than to evaluate this Proposal. The data subject to this restriction are contained in sheets (insert page numbers or other identification).”
2. The Agencies, for purposes of this provision, will include any consultants assisting in the evaluation of Proposals. If, however, a contract is awarded to the Respondent as a result of or in connection with the submission of this data, the Agencies have the right to duplicate, use, or disclose the data to the extent provided in the resulting contract. This restriction does not limit the Agencies’ rights to use information contained in the data if it is obtained from another source without restriction.

(ii) Mark each sheet or data to be restricted with the following legend: “Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this Proposal.”

**All submissions are subject to the Illinois Freedom of Information Act (FOIA).**

**C. Agencies' Right to Reject Proposals**

The COC, acting through its Deferred Compensation Committee, reserves the right to reject any and all Proposals that do not conform to the requirements set forth in this RFP; or that do not contain the information required by this RFP.

**D. No Liability for Costs**

The City is not responsible for costs or damages incurred by Respondents, member(s), partners, subcontractors or other interested parties in connection with the RFP process, including but not limited to costs associated with preparing the Proposal and of participating in any site visits, product system demonstrations, oral presentations, or negotiations.

**E. Prohibition on Certain Contributions – Mayoral Executive Order No. 2011-4**

No Contractor or any person or entity who directly or indirectly has an ownership or beneficial interest in Contractor of more than 7.5% ("Owners"), spouses and domestic partners of such Owners, Contractor’s Subcontractors, any person or entity who directly or indirectly has an ownership or beneficial interest in any Subcontractor of more than 7.5% ("Sub-owners") and spouses and domestic partners of such Sub-owners (Contractor and all the other preceding classes of persons and entities are together, the "Identified Parties"), shall make a contribution of any amount to the Mayor of the City of Chicago (the "Mayor") or to his political fundraising committee during (i) the bid or other solicitation process for this Contract or Other Contract, including while this Contract or Other Contract is executory, (ii) the term of this Contract or any Other Contract between City and Contractor, and/or (iii) any period in which an extension of this Contract or Other Contract with the City is being sought or negotiated.

Contractor represents and warrants that since the date of public advertisement of the specification, request for qualifications, request for proposals or request for information (or any combination of those requests) or, if not competitively procured, from the date the City approached the Contractor or the date the Contractor approached the City, as applicable, regarding the formulation of this Contract, no Identified Parties have made a contribution of any amount to the Mayor or to his political fundraising committee.

Contractor shall not: (a) coerce, compel or intimidate its employees to make a contribution of any amount to the Mayor or to the Mayor’s political fundraising committee; (b) reimburse its employees for a contribution of any amount made to the Mayor or to the Mayor’s political fundraising committee; or (c) bundle or solicit others to bundle contributions to the Mayor or to his political fundraising committee.

The Identified Parties must not engage in any conduct whatsoever designed to intentionally violate this provision or Mayoral Executive Order No. 2011-4 or to entice, direct or solicit others to intentionally violate this provision or Mayoral Executive Order No. 2011-4.

Violation of, non-compliance with, misrepresentation with respect to, or breach of any covenant or warranty under this provision or violation of Mayoral Executive Order No. 2011-4 constitutes a breach and default under this Contract, and under any Other Contract for which no opportunity to cure will be granted. Such breach and default entitles the City to all remedies (including without limitation termination for default) under this Contract, under Other Contract, at law and in equity. This provision amends any Other Contract and supersedes any inconsistent provision contained therein.

If Contractor violates this provision or Mayoral Executive Order No. 2011-4 prior to award of the Contract resulting from this specification, the CPO may reject Contractor’s bid.

For purposes of this provision:

"Other Contract" means any agreement entered into between the Contractor and the City that is (i) formed under the authority of MCC Ch. 2-92; (ii) for the purchase, sale or lease of real or personal property; or (iii) for materials, supplies, equipment or services which are approved and/or authorized by the City Council.

"Contribution" means a "political contribution" as defined in MCC Ch. 2-156, as amended.

"Political fundraising committee" means a "political fundraising committee" as defined in MCC Ch. 2-156, as amended.

**F. False Statements**

(a) 1-21-010 False Statements

Any person who knowingly makes a false statement of material fact to the city in violation of any statute, ordinance or regulation, or who knowingly falsifies any statement of material fact made in connection with an application, report, affidavit, oath, or attestation, including a statement of material fact made in connection with a bid, proposal, contract or economic disclosure statement or affidavit, is liable to the city for a civil penalty of not less than $500.00 and not more than $1,000.00, plus up to three times the amount of damages which the city sustains because of the person's violation of this section. A person who violates this section shall also be liable for the city's litigation and collection costs and attorney's fees.

The penalties imposed by this section shall be in addition to any other penalty provided for in the municipal code. (Added Coun. J. 12-15-04, p. 39915, § 1)

(b) 1-21-020 Aiding and Abetting.

Any person who aids, abets, incites, compels or coerces the doing of any act prohibited by this chapter shall be liable to the city for the same penalties for the violation. (Added Coun. J. 12-15-04, p. 39915, § 1)

(c) 1-21-030 Enforcement.

In addition to any other means authorized by law, the corporation counsel may enforce this chapter by instituting an action with the department of administrative hearings. (Added Coun. J. 12-15-04, p. 39915, § 1)

**G. Required Content of Proposals**

At a minimum, the Proposal must include the following information:

**1. Cover Letter**

Respondent must submit a cover letter signed by an authorized representative of its company. The letter must:

1. outline the number of years the company has been in business
2. provide an overview of the experience and background of the company and its committed key personnel
3. identify the legal name of the company
4. indicate its headquarters address
5. indicate its principal place of business
6. indicate its legal form (i.e. corporation, joint venture, limited partnership, etc.).  **If Respondent is a business entity that is comprised of more than one legal participant (e.g., Respondent is a limited partnership, joint venture, etc.), then Respondent must identify or cause to be identified all participants involved, their respective ownership percentages, and summarize the role, degree of involvement, and experience of each participant separately**.
7. indicate the names of its principals or partners
8. indicate the name and telephone number(s) of the principal contact for oral presentation or negotiations
9. indicate the Respondent’s commitment to provide the work as described in this RFP.
10. summarize Respondent's approach to MBE/WBE participation (see Exhibit V, to this RFP).
11. validate whether Respondent is authorized to do business in the State of Illinois
    1. Attach copies of appropriate licenses or certifications required of any individual or entity performing the Services described in this RFP in the City of Chicago, County of Cook, and State of Illinois, for itself, its partners and its subcontractors, including evidence that Respondent is authorized by the Secretary of State to do business in the State of Illinois. Provide copies with the Proposal submission.
    2. These requirements will vary depending upon the circumstances of each Respondent. See the Chicago Department of Business Affairs and Consumer Protection (BACP) website for additional information: [www.cityofchicago.org/businessaffairs](http://www.cityofchicago.org/businessaffairs).
    3. If required by law, Respondents are required to have an Illinois Business License. See the State of Illinois, Department of Business Services website for additional information: www.cyberdriveillinois.com (<http://www.cyberdriveillinois.com/>).
    4. Additionally, visit the State of Illinois’ Division of Professional Regulation for information regarding the State of Illinois’ Professional Certifications: <http://www.idfpr.com/DPR/>.
12. indicate which, if any, questions or requests for one or more responses have not been addressed.

**2. Overview of Respondent(s) Plan for Implementing and Providing the Services**

Respondent must provide a detailed summary of its plan for its initial implementation phase(s), and ongoing provision of the services described in this RFP; a detailed Plan transition strategy along with communication materials to explain any new Plan changes and enhancements. The potential conversion from the current Plan provider to a new provider will require Respondent to provide an explanation of the process to be implemented in order to mitigate any loss of continuity or inability to deliver services during such transition periods in order to meet the Agencies’ January 1, 2016 effective date.

**3. Respondent(s) Professional Qualifications and Specialized Experience**

Respondent must describe its previous experience on recent HMO Plan engagements of similar type, scope and magnitude, identifying both private sector and public sector work.

**4. Professional Qualifications, Specialized Experience and Local Availability of Key Personnel Committed to this Project**

A. Respondent must provide a summary of the personnel who will be dedicated to the “Services”.

1. Respondent must submit resumes, or corporate personnel profiles, with past experience for each of the key personnel. 3**Also, Respondent must provide evidence that the company is licensed in Illinois, with demonstrated experience in managing government sector accounts.**
2. Respondent must provide evidence of any and all licensing and registration in order to provide Services required per this RFP, including any certification as a qualified firm to provide Services.

**5. Fee Proposal**

Respondent must address the questions set forth in Exhibit II and provide a detailed fee proposal for the required Services according to the scenarios described in Exhibit II.

**6. MBE/WBE Commitment**

Respondent shall address its MBE/WBE compliance plan, to evidence Respondent’s proposed direct MBE/WBE participation, in response to this RFP and in accordance with the Exhibit V stated requirements for each Agency.

**7. Legal Actions**

Respondent must provide a listing and a brief description of all material legal actions, together with any fines and penalties, for the past 5 years in which: (i) Respondent or any division, subsidiary or parent entity of Respondent, or (ii) any member, partner, etc., of Respondent ,if Respondent is a business entity other than a corporation, has been:

(i) A debtor in bankruptcy; or

(ii) A plaintiff or defendant in a legal action for deficient performance under a contract or violation of a statute or related to service reliability; or

(iii) A respondent in an administrative action for deficient performance on a project or in violation of a statute or related to service reliability; or

(iv) A defendant in any criminal action; or

(v) A named insured of an insurance policy for which the insured has paid a claim related to deficient performance under a contract or in violation of a statute or related to service reliability; or

(vi) A principal of a bond for which a surety has provided contract performance or compensation to an obligee of the bond due to deficient performance under a contract or in violation if a statute or related to service reliability; or

(vii) A defendant or respondent in a governmental inquiry or action regarding accuracy of preparation of financial statements or disclosure documents. The Agencies reserves the right to request similar legal action information from Respondent’s team members during the evaluation process.

The Agencies reserves the right to request similar legal action information from Respondent’s team members during the evaluation process.

**8. Financial Statements**

Respondent should provide a copy of its audited financial statements for the last 3 years. Respondents that are comprised of more than one entity must include financial statements for each entity. The Agencies reserves the right to accept or reject any financial documentation other than the financial statements requested by this section.

If Respondent is unable to provide audited financial statements, state the reasons in your Proposal response and provide financial documentation in sufficient detail to enable the Agencies to assess the financial condition of your company.

Sufficient alternate documentation would be unaudited financial statements from those Respondents not required to have their financial statements audited. At a minimum, the statements need to be the balance sheets and income statements (or equivalent) for the requested three years. Assets/liabilities and income/expenses must be presented in adequate detail for the City to assess the financial condition of the Respondent.

**9. Economic Disclosure Statement and Affidavit (“EDS”) for Agencies**

For COC:

Respondent must submit a completed and executed Economic Disclosure Statement and Affidavit and the Appendix A for the COC. See hardcopy EDS forms and Online City of Chicago EDS Instructions and Attachment A Online EDS Acknowledgement in Exhibit VI-A. Upon completion of Online EDS, Respondent shall submit a copy of 2 documents with their proposal: 1) Certificate of Filing printed from system and 2) hardcopy of the executed Attachment A, Online EDS Acknowledgement form in lieu of hardcopy EDS forms.

Subcontractors may be asked, at the City’s discretion, to provide an EDS during the evaluation process.

For CPD:

Respondent must submit a completed and executed Economic Disclosure Statement and Affidavit per Exhibit VI-B.

For CPS:

Respondent must submit a notarized Contractor’s Disclosure Form per Exhibit VI-C.

**10. Insurance**

Prior to contract award, the selected Respondent will be required to submit evidence of insurance in the amounts specified in the attached Exhibit VIII for each Agency.

**11. Exceptions**

Identify any exceptions to the terms and conditions of the RFP indicated in the Sample boilerplate contract languages provided in Exhibit IX, if such terms would be included as part of the Agreement with the Selected Respondent.

**IV. EVALUATING PROPOSALS**

An evaluation committee shall be appointed in cooperation among Agency department heads, and shall include subject matter experts from the various Agencies ("Evaluation Committee") as well as third party consultants for the Agency(s). The Evaluation Committee (EC) will review and evaluate each Respondent’s Proposal, as described below.

***Phase I – Completeness of Proposals and Minimum Qualifications of Respondent***

The EC) will first examine proposals to eliminate those that are clearly non-responsive to the stated requirements. Therefore, Respondents should exercise particular care in reviewing the proposal format required for this RFP.

Respondent must meet (and must provide evidence to demonstrate) all of the following minimum qualifications listed below, in order to be given further consideration. If a proposal is submitted by a Respondent that does not satisfy the minimum qualifications listed below, it will not be reviewed further or be considered for award.

1. Must have a program in place to provide individual participant services supported by customer service representatives.
2. Respondents that propose a subcontractor service organization to provide Services, must have an established relationship with those subcontractors for a minimum of approximately 5 years with programs similar in size to the Agencies.
3. Must have at least three medical Plan accounts, each having approximately 25,000 employees per account.
4. Must not be a broker.

***Phase II – Detailed Proposal Review***

After the minimum qualifications above have been determined, the EC will review all other RFP submittals in detail. The EC may also review any other information that is available to it, including but not limited to information gained by checking references and by investigating the Respondent’s financial condition.

All aspects of the required services will be fully evaluated including the completeness and accuracy of Respondent's Proposal.

The EC expects each Respondent to clearly outline their firm’s best and most comprehensive resources. The EC may consider any factors it deems necessary and proper to determine the best value, including but not limited to:

1. **Focus on Quality and Consistency of Service Delivery**

* Adherence to successful quality assurance procedures;
* Execute a successful problem resolution methodology;
* Provide a history of performing services on a timely basis;
* Perform services correctly and accurately;
* Provide accurate and consistent responses to inquiries; and
* Provide reports with statistical analyses.

1. **Proactive Approach**

* Educate Subscribers through participant-friendly communications;
* Educate Subscribers by providing informed toll-free customer service center and field service representatives; and
* Provide, at minimum, annual on-site visits to individual Agency departments or Subscribers enrollment, and guest-speaking group meetings when required.
* Participate in on-going employee training sessions that discuss health and wellness issues as relates to changes to the health care services landscape.

1. **Commitment to Technology Development**

* Maintain currency with technological developments such as mobile Internet access;
* Continuous investments in enhanced technology and security protections; and
* Improvements (in accuracy, and timeliness, etc.) in keeping pace with delivering Subscriber Services as relates to technological advancements.

1. Extent of commitment to on-site employee enrollment, ongoing communication, customer service, and employee education, including superior web services and automated voice response system (VRS).
2. Data-management services, including creation and maintenance of employee data, transaction data and history, interfaces with data resources, administrative functions, including compliance.
3. Size, structure, resources, and experience in providing Services that are similar in size and scope to that of the Agencies.
4. Solutions offered to satisfy the Scope of Service requirements and any value through performance guarantees.
5. Technical Competence as Evidenced by:
   1. Respondent's professional qualifications and depth of specialized experience, which is necessary for the satisfactory performance of Services, including availability of adequate personnel;
   2. The professional qualifications and specialized experience of committed personnel specific to understand and manage the Agencies;
   3. Respondent's past performance on similar type contracts, in terms of quality of services, managing of conjoined individual sister governmental agencies (not interdepartmental governmental agencies), and compliance with healthcare related laws and effects. The City may solicit from previous clients, including any of the Agencies, or any available sources, relevant information concerning Respondent's record of past performance;
6. Insurance – Compliance with Insurance Requirements in Exhibit IV parts A-C.
7. Cost – Respondent's Fee proposal and overall cost structure. The EC will carefully examine all the costs associated with each Respondent’s products and services. Each Respondent will be required to fully disclose fees based on the Plan information provided in this RFP.
8. Financial Stability – The EC will consider the financial condition of Respondent. Respondent must be financially stable to ensure performance over the duration of the contract.
9. Respondent’s indication of its compliance with all laws, ordinances, and statutes governing the contract.
10. Conflict of Interest – The EC will consider any information regarding Respondent, including information contained in Respondent’s Proposal, that may indicate any conflicts (or potential conflicts) of interest which might compromise Respondent’s ability to satisfactorily perform the proposed Services or undermine the integrity of the competitive procurement process.

If any Respondent has provided any services for either of the Agencies, in researching, consulting, advising, drafting or reviewing of this RFP or any services related to this RFP, such Respondent may be disqualified from further consideration.

1. The EC will consider any legal actions, if any, against Respondent and any division, subsidiary or parent company of Respondent, or against any member, partner, etc., of Respondent if Respondent is a business entity other than a corporation.
2. The EC will consider the degree to which the Respondent accepts the COC’s Sample Professional Services Agreement in Exhibit VII-A, and CPD General Terms and Conditions Sample, since such acceptance may impact contract negotiations. (The CPS’s contract terms and conditions are to be determined, but shall mirror the City of Chicago’s, to the extent applicable.)

Subsequent to the evaluation of the factors set forth above in Phase I and Phase II, the EC will consider the level, relevancy, and quality of participation by MBE/WBE firms certified in accordance with each Agency’s MBE/WBE requirements.

The Agencies reserve the right to seek clarification of any information that is submitted by any Respondent in any portion of its Proposal or to request additional information during the evaluation process. Any material misrepresentation made by a Respondent may void the Proposal and eliminate the Respondent from further consideration.

***Phase III – Oral Presentations***

After the EC completes its detailed review of Proposals, it will decide upon a short list of Respondents who may be considered for contract award, and, as an option before making a final decision invite the short-listed Respondents to appear before the EC to, for example: discuss and clarify in more detail, information that was submitted in the Respondent’s Proposal; ask such Respondents to respond to additional questions, if applicable; and demonstrate the hosted system user-experience.

It is expected that the invitees being considered for award will bring to the meeting those subject matter experts who can best address the core business requirements, as well those who will work directly with the Agencies. (Travel expenses and costs related to the oral presentation meetings are the responsibility of the Respondent.)

**V. RESPONDENT SELECTION PROCESS**

After orals, the EC will make a final evaluation, including a final ranking of the Respondents, and may request a Best and Final Offer (BaFO) before submitting its recommendation to their respective Agency authorities, to begin negotiations towards contract award.

Upon receipt of the EC’s recommendation, the Agencies will make the final selection and commence negotiations with the Selected Respondent(s).

The negotiation process is not a binding commitment to award a contract. If the Agency determines that it is unable to reach an agreement with the Selected Respondent, the Agency may terminate negotiations with the Selected Respondent and may elect to negotiate with any of the other highly ranked Respondents, until such time as a favorable negotiated contract is achieved.

The Selected Respondent(s) shall be required to immediately participate in contract negotiations. The extent to which a softcopy of a draft Agreement can be created by the Selected Respondent(s), to be used as the starting point for the final executable version, will help expedite the contract award process.

The Selected Respondent(s) must be willing to sign the Agreement (either as a joint Agreement among the Agencies, or separately between individual Agencies) having a base period of three (3) years from the effective date, including the fourth and fifth year extension options.

The Agencies reserve the right to terminate this RFP solicitation in part or in whole at any stage, if the Agency determines such action to be in its best interest. The receipt of Proposals or other related submittal documents will in no way obligate any of the Agencies to enter into any contract of any kind with any party.

EXHIBIT 1 - A

**Benefits Plan**

**City of CHICAGO**

**HMO Plans of Benefits**

**Certificates of Coverage**

**Summary Guides**

HMO Certificates of Coverage and HMO pages within the Summary Guides, for both Plan A and Plan B, are all available on the City’s benefits website:

Go to: cityofchicago.org/benefits

* For the Plan A and Plan B HMO Certificates of Coverage click on “Employee / Annuitant Handbooks” and then scroll down until you find: “Group A Medical HMO Plan Booklet, effective 1/1/2014” and “Group B Medical HMO Plan Booklet, effective 1/1/2014”
* Also on this same website page you will find pages in the Plan A and Plan B Summary Guides pertaining to the HMO. Scroll down until you find Group A Summary Guide and Group B Summary Guide. When you click on the Summary Guides, scroll forward 4 or 5 pages to the HMO information.

EXHIBIT 1 - B

**Benefits Plan**

**CHICAGO PARK DISTRICT**

<< attached by reference >>

EXHIBIT 1 - C

**Benefits Plan**

**CHICAGO PUBLIC SCHOOLS**

<< attached by reference >>

EXHIBIT II

**COST PROPOSAL**

1. The three Agencies request that you offer price quotes on the following basis:
   1. Basis #1-- Current Network
      1. Capitated physician services--specify in detail those services that are subject to the capitation. Describe in detail how capitation will be charged to the Agency for its members. Assume that membership continues as per the enrollment data file for purposes of estimation for 2016. If the basis of payment to the providers is different than the basis charged to the Agency, identify the differences between the rate you charge the Agency and the rate you pay the providers and any tiering differences.
      2. Fee for service for non-capitated services. Estimate based on the provided claim data file for 2016.
      3. Inclusive of prescription drugs. Specify the basis of charge for brand drugs, generic drugs and specialty drugs assuming that the Plan uses your preferred drug list. Specify any dispensing fees at retail and mail; specify any rebates received and the degree to which those rebates would be passed back to the Agency. Specify any charges for drug utilization review programs currently in place.
      4. Administrative service fee. Specify for each of the three years of the proposed contract.
   2. Basis #2 -- Current Network exclusive of Advocate Facilities (assume Advocate use fully migrates to PPO product)
      1. Capitated physician services--specify in detail those services that are subject to the capitation. Describe in detail how capitation will be charged to the Agency for its members. Assume that membership continues as per the enrollment data file for purposes of estimation for 2016. If the basis of payment to the providers is different than the basis charged to the Agency, identify the differences between the rate you charge the Agency and the rate you pay the providers and any tiering differences.
      2. Fee for service for non-capitated services. Estimate based on the provided claim data file for 2016.
      3. Inclusive of prescription drugs. Specify the basis of charge for brand drugs, generic drugs and specialty drugs assuming that the Plan uses your preferred drug list. Specify any dispensing fees at retail and mail; specify any rebates received and the degree to which those rebates would be passed back to the Agency. Specify any charges for drug utilization review programs currently in place.
      4. Administrative service fee
   3. Basis #3 -- Current Network
      1. Capitated physician services--specify in detail those services that are subject to the capitation. Describe in detail how capitation will be charged to the Agency for its members. Assume that membership continues as per the enrollment data file for purposes of estimation for 2016. If the basis of payment to the providers is different than the basis charged to the Agency, identify the differences between the rate you charge the Agency and the rate you pay the providers and any tiering differences.
      2. Fee for service for non-capitated services. Estimate based on the provided claim data file for 2016.
      3. Prescription drugs excluded/carved-out
      4. Administrative service fee
   4. Basis #4 -- Current Network exclusive of Advocate Facilities (assume Advocate use fully migrates to PPO product)
      1. Capitated physician services--specify in detail those services that are subject to the capitation. Describe in detail how capitation will be charged to the Agency for its members. Assume that membership continues as per the enrollment data file for purposes of estimation for 2016. If the basis of payment to the providers is different than the basis charged to the Agency, identify the differences between the rate you charge the Agency and the rate you pay the providers and any tiering differences.
      2. Fee for service for non-capitated services. Estimate based on the provided claim data file for 2016.
      3. Prescription drugs excluded/carved out
      4. Administrative service fee
   5. For any proposer bidding on an EPO basis, proposer must submit an estimate of expenses for what would be capitated physician services and a robust explanation of the estimation methodology. Proposer should separately confirm that it can match the network limitations described above; in the event that it cannot, it must specifically list any variations from the existing network of service providers.

2. Describe in detail how you determined the administrative service fee in your proposal. List all services included in the administrative service fee. Describe any offsets or other forms of consideration that were considered in the determination of the administrative service fee. For example, if the proposer receives drug rebates or other considerations from certain vendors for home health services and the amount of those rebates/other considerations was considered in reaching the administrative service fee, disclose those sources of reduction and identify the expected value of those items. Provide an exhibit that identifies all sources of cost and reductions to cost that were used in determining the administrative service fee proposal.

1. Describe in detail any retentions other than the administrative fee kept by the proposer. For example, if the proposer pays any vendors a different amount than the amount billed to the account for a service, detail the amount of any spread between the actual amount paid by the proposer and the amount paid by the Agency. Estimate the value of any such retentions for each year of the contract. Include any amounts related to bonus pool or other physician compensation that is not paid to providers (who did not reach bonus goals). Include any spread between the estimated capitation amounts identified in your proposal and actual capitation paid to providers.
2. For those proposers who are current services providers of HMO services to an Agency, for each of the last two years (2014 and 2013) prepare an exhibit that accounts for actual financial performance of the program based on actual incurred expenses for each of the following items:
   * 1. Cost of care not covered by capitation payments
        1. Amount actually billed to Agency for these services
        2. Amount actually paid to providers for these services
        3. Amount retained by proposer (#1 less #2)
        4. Amounts received as rebates/refunds pursuant to contractual arrangements if not specifically accounted for above.
     2. Capitation payments
        1. Amount charged to the Agency for these services
        2. Amount actually paid to providers for these services
           1. Amounts paid for care (direct capitation)
           2. Amounts paid for bonus/quality programs (includes any type of compensation paid in addition to direct capitation).
        3. Amount withheld/retained by proposer (#1 less #2)
     3. Cost of prescription drugs (if applicable to the given Agency)
        1. Amount charged to the Agency for prescription drugs (prior to rebates); Specify the basis of charge for brand drugs, generic drugs and specialty drugs assuming that the Plan uses your preferred drug list. Specify any dispensing fees at retail and mail; specify any rebates received and the degree to which those rebates would be passed back to the Agency. Specify any charges for drug utilization review programs currently in place.
        2. Amount actually paid for prescription drugs (prior to rebates)
        3. Amount of rebates refunded to Agency
        4. Amount of rebates/other sources withheld by proposer.
        5. Amounts retained by proposer.
     4. Administrative fee/proposer retention
        1. Calculate Administrative fee/ Proposer retention prior to disclosure of additional retention items: Premium received less:
           1. Cost of care billed to Agency
           2. Capitation payments billed to Agency
           3. Prescription Drugs billed to Agency net of rebates credited to Agency
           4. Develop PMPM and PEPM amounts.
        2. Calculate Actual Administrative fee/Proposer retention: Premium received less:
           1. Actual cost of care
           2. Actual capitation payments inclusive of direct capitation and quality/bonus payments
           3. Actual cost of prescription drugs net or rebates/other considerations
           4. Develop PMPM and PEPM amounts.
3. Do you believe that the HMO model (inclusive of capitation payments to physicians) is viable for the next five years? Why or why not?
4. List all quality/bonus programs that are operational in 2015. If you expect to change those programs or add new programs for 2016 and/or 2017, please provide information on the expected program changes.
5. Will you allow an Agency to customize the HMO network it offers to its members? If no, why not?
6. Can you support an Agency who wishes to charge variable premiums based on PCP selection? For example, if the Agency would wish to charge more premium for the more expensive physician groups, can you administratively support that effort? How many premium tiers/amounts can you support? ? Is there anything in your current provider contracts that would prevent this type of arrangement?
7. Can you support an Agency that wishes to provide a lower level of benefits in the HMO program for the most/more expensive physician groups? For example, if IPA #1, #3 and #5 are 30% more expensive than the next group of IPAs, can you support a different plan of benefits (higher co-pays, OPX, etc.) for IPA #1, #3 and #5 while leaving the other IPAs with the existing benefit structure? How many variations could you support? 3-tiers? 5-tiers? Is there anything in your current provider contracts that would prevent this type of arrangement?
8. What steps have you taken in the last three years to contain health care expenditures in the HMO? What have been the results of your efforts? Specific Agency and quantification of financial results would be appreciated. More general statements without quantification are discouraged.
9. If you are proposing on the basis of an EPO arrangement with no physician capitation, do you believe that the expense levels will be different than the expense levels in the PPO plan offered by the employer? Why or why not?
10. If you are proposing on a basis that includes capitation payments to physicians, are you willing/able to offer the program on a non-insured basis rather than an insured basis? Why or why not?
11. If you are proposing on the basis of an EPO arrangement with no physician capitation, what support can you offer an Agency who would be moving from a physician capitation arrangement? Have you taken over any cases where the account moved from physician capitation to non-capitated physician reimbursement? If yes, what were the results? Are you willing to offer a "not to exceed" guarantee or risk corridor arrangement to an Agency? If yes, specify those terms. If no, why not?
12. If you are proposing on the basis of an EPO arrangement with no physician capitation, is your proposed administrative fee the same as or different than what you would propose for a PPO arrangement for the same size group? If there is any difference, why?
13. Does the State of Illinois license your EPO as an EPO?
14. Included with the RFP is a claim file for you to re-price to reflect your contractual arrangements with your vendors. The reported re-priced amount should be the allowable charge (you do not have to apply the plan of benefits). Use your pricing as of the date of service indicated in the claim record. If you do not have a contractual arrangement with a vendor within the service area (Metropolitan Chicago six County area, {Cook and collar}), do not re-price the claim. For those claims please provide a separate file with no pricing information. For out of service area claims, price at the allowable amount. The purpose of this exercise is to allow the Agency to compare what was paid under its current arrangement with what would have been paid should it have had a contract with the responding proposer. From time to time respondents have not been aware of this goal and have provided "average" or "adjusted" or "expected" or "best available" reimbursement rather than actually adjudicating the claim in accordance with their contractual arrangements at the time the claim was incurred. Proposers are encouraged to complete this exercise as requested. Any deviations from the requested re-pricing exercise should be noted and explained.
15. For the Chicago Public Schools, please complete the following table:

|  |  |  |  |
| --- | --- | --- | --- |
|  | |  |  |
|  | |  |  |
|  | | Enrollment | Carrier Proposed |
|  | |  |  |
| **Admin Fees** | |  |  |
| BC/BS HMO IL - PEPM | | 15,404 | $0.00 |
| UHC EPO Plan - PEPM | | 3,027 | $0.00 |
| **Annual Total** | | 18,431 | $0 |
|  | |  |  |
| **Capitations** | |  |  |
| BC/BS HMO IL - Single | | 6,252 | $0.00 |
| BC/BS HMO IL - Family | | 9,152 | $0.00 |
| UHC EPO Plan - Single | | N/A | $0.00 |
| UHC EPO Plan - Single | | N/A | $0.00 |
| **Annual Total** | | 15,404 | $0 |
|  | |  |  |
| **Expected Claims** | |  |  |
| BC/BS HMO IL - PEPM | | 15,404 | $0.00 |
| UHC EPO Plan - PEPM | | 3,027 | $0.00 |
| **Annual Total** | | 18,431 | $0 |
|  | |  |  |
|  | |  |  |
|  | |  | $0 |
|  | |  | $0 |
|  | |  | $0 |
| **Combined Annual Total** | |  | $0 |
|  | |  |  |
|  | |  |  |
|  |

EXHIBIT III

RESERVED

EXHIBIT IV – A1 HMO

**Insurance Requirements**

**CITY OF CHICAGO**

<< attached by reference >>

EXHIBIT IV – A2 HMO Contracted Hospitals

**Insurance Requirements**

**CITY OF CHICAGO**

<< attached by reference >>

EXHIBIT IV – A3 Other-than Hospitals

**Insurance Requirements**

**CITY OF CHICAGO**

<< attached by reference >>

EXHIBIT IV – A4 Pharmacy

**Insurance Requirements**

**CITY OF CHICAGO**

**INSURANCE REQUIREMENTS**

HMO Pharmacy Benefits Management

**Pharmacy Benefits Manager**

Contractor must provide and maintain at Contractor's own expense or cause to be provided, during term of the Agreement and time period following expiration if Contractor is required to return and perform any of the Services or Additional Services under this Agreement, the insurance coverages and requirements specified below, insuring all operations related to the Agreement.

**A. INSURANCE TO BE PROVIDED BY CONTRACTOR**

1) Workers Compensation and Employers Liability

Workers Compensation Insurance, as prescribed by applicable law covering all employees who are to provide a service under this Agreement and Employers Liability coverage with limits of not less than $100,000 each accident or illness.

2) Commercial General Liability (Primary and Umbrella)

Commercial General Liability Insurance or equivalent with limits of not less than $10,000,000 per occurrence for bodily injury, personal injury and property damage liability. Coverages must include the following: All premises and operations, products/completed operations, separation of insureds, defense, and contractual liability (not to include Endorsement CG 21 39 or equivalent). The City of Chicago is to be named as an additional insured on a primary, non-contributory basis for any liability arising directly or indirectly from the work or Services.

3) Automobile Liability (Primary and Umbrella)

When any motor vehicles (owned, non-owned and hired) are used in connection with services to be performed, Contractor must provide Automobile Liability Insurance with limits of not less than $1,000,000 per occurrence for bodily injury and property damage. The City of Chicago is to be named as an additional insured on a primary, non-contributory basis.

1. Professional/Pharmacists Liability

When any Pharmaceutical Services or other professional services are performed in connection with this Agreement, Professional/Pharmacists Liability Insurance must be maintained covering acts, errors, or omissions related to the dispensing of drugs or pharmacy activities with limits of not less than $10,000,000. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede start of Services on the Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of two (2) years.

5) Blanket Crime

Crime Insurance or equivalent covering all persons handling funds under this Agreement, against loss by dishonesty, robbery, destruction or disappearance, computer fraud, credit card forgery and other related crime risks. The policy limit must be written to cover losses in the amount of maximum monies collected, received and in the possession of Contractor at any given time.

**B. INSURANCE COVERAGE TO BE MAINTAINED** **BY CHAIN RETAIL PHARMACIES**

1) Workers Compensation and Employers Liability

Workers Compensation Insurance, as prescribed by applicable law covering all employees

who are to provide a service under this Agreement and Employers Liability coverage with limits of not less than $100,000 each accident or illness.

2) Commercial General Liability (Primary and Umbrella)

Commercial General Liability Insurance or equivalent with limits of not less than $5,000,000 per occurrence for bodily injury, personal injury, and property damage liability. Coverages must include the following: All premises and operations, products/completed operations, separation of insureds, defense, and contractual liability (not to include Endorsement CG 21 39 or equivalent). The City of Chicago is to be named as an additional insured on a primary, non-contributory basis for any liability arising directly or indirectly from the work or Services.

3) Automobile Liability (Primary and Umbrella)

When any motor vehicles (owned, non-owned and hired) are used in connection with services to be performed, Chain Retail Pharmacies must provide Automobile Liability Insurance with limits of not less than $1,000,000 per occurrence for bodily injury and property damage.

4) Professional/Pharmacists Liability

When any Pharmaceutical Services are performed in connection with this Agreement, Professional/Pharmacists Liability Insurance must be maintained covering acts, errors, or omissions related to the dispensing of drugs or pharmacy activities with limits of not less than $5,000,000. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, start of Services on the Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of two (2) years.

**C. ADDITIONAL REQUIREMENTS**

Contractor must furnish the City of Chicago, Benefits Management Office, Room 400, 333 South State Street, Chicago, IL 60604-3978 original Certificates of Insurance, or such similar evidence, to be in force on the date of this Agreement, and Renewal Certificates of Insurance, or such similar evidence, if the coverages have an expiration or renewal date occurring during the term of this Agreement. Contractor must submit evidence of insurance on the City of Chicago Insurance Certificate Form (copy attached) or equivalent prior to execution of Agreement. The receipt of any certificate does not constitute agreement by the City that the insurance requirements in the Agreement have been fully met or that the insurance policies indicated on the certificate are in compliance with all requirements of Agreement. The failure of the City to obtain certificates or other insurance evidence from Contractor is not a waiver by the City of any requirements for Contractor to obtain and maintain the specified coverages. Contractor must advise all insurers of the Agreement provisions regarding insurance. Non-conforming insurance does not relieve Contractor of the obligation to provide insurance as specified in this Agreement. Non-fulfillment of the insurance conditions may constitute a violation of the Agreement, and the City retains the right to suspend this Agreement until proper evidence of insurance is provided, or the Agreement may be terminated.

The Contractor must provide for 60 days prior written notice to be given to the City in the event coverage is substantially changed, canceled, or non-renewed.

Any deductibles or self-insured retention on referenced insurance coverages must be borne by Contractor.

Contractor hereby waives and agrees to require their insurersto waive their rights of subrogation against the City of Chicago, its employees, elected officials, agents, or representatives.

The coverages and limits furnished by Contractor in no way limit the Contractor’s liabilities and responsibilities specified within the Agreement or by law.

Any insurance or self-insurance programs maintained by the City of Chicago do not contribute with insurance provided by the Contractor under the Agreement.

The required insurance to be carried is not limited by any limitations expressed in the indemnification language in this Agreement or any limitation placed on the indemnity in this Agreement given as a matter of law.

If Contractor is a joint venture or limited liability company, the insurance policies must name the joint venture or limited liability company as a named insured.

Contractor must require all subcontractors to provide the insurance required herein**,** or Contractor may provide the coverages for subcontractors. All subcontractors are subject to the same insurance requirements of Contractor unless otherwise specified in this Agreement.

If Contractor or subcontractor desire additional coverages, the party desiring the additional coverages is responsible for the acquisition and cost.

Notwithstanding any provisions in the Agreement to the contrary, the City of Chicago Risk Management Department maintains the right to modify, delete, alter or change these requirements.



EXHIBIT IV - B

**Insurance Requirements**

**CHICAGO PARK DISTRICT**

<< attached by reference >>

EXHIBIT IV - C

**Insurance Requirements**

**CHICAGO PUBLIC SCHOOLS**

<< attached by reference >>

EXHIBIT V – A

**City of Chicago**

**SPECIAL CONDITIONS REGARDING MINORITY AND WOMEN OWNED BUSINESS ENTERPRISE (MBE/WBE) COMMITMENT**

**AND SCHEDULES**

<< attached by reference >>

EXHIBIT V – B

**Chicago park district**

**COMPLIANCE CONDITIONS REGARDING PARTICIPATION BY MINORITY- AND WOMEN-OWNED BUSINESS ENTERPRISES**

<< attached by reference >>

EXHIBIT V – C

**CHICAGO PUBLIC SCHOOLS**

**REMEDIAL PROGRAM FOR MINORITY AND WOMEN BUSINESS ENTERPRISE ECONOMIC PARTICIPATION**

<< attached by reference >>

EXHIBIT VI – A

**CITY OF CHICAGO**

**online CITY OF CHICAGO ECONOMIC DISCLOSURE**

**STATEMENT AND AFFIDAVIT (EDS) INSTRUCTIONS**

WHEN SUBMITTING your RESPONSE TO thIS request for Proposal (RFP) for **DEFERRED COMPENSATION SERVICES** for the City of Chicago, specification no. 131782, THE Respondent SHALL submit 2 DOCUMENTS: 1) a “**certificate of filing**” evidencing completion of your online EDS AND 2) an EXECUTED **ATTACHMENT a, onLine eds Acknowledgement** SIGNED BY AN AUTHORIZED OFFICER BEFORE A NOTARY.

**1. online eds filing**

**1.1. Online EDS Filing Required Prior To response due date**

The Respondent shall complete an online EDS prior to the response due date. A Respondent who does not file an electronic EDS prior to the response due date may be found non-responsive and its response rejected. If you are unable to complete the online EDS and print a Certificate of Filing prior to the response due date, the City will accept a paper EDS provided written justification is provided explaining your good faith efforts to complete it before the response due date and the reasons why it could not be completed.

**NOTE: ALWAYS SELECT THE “CONTRACT” (NOT UPDATE) BOX WHEN COMPLETING AN ONLINE EDS TO ENS****URE A NEW CONTRACT SPECIFIC ONLINE EDS IS CREATED RELATED TO THE SOLICITATION DOCUMENT. CLICKING THE UPDATE BOX ONLY UPDATES PREVIOUS EDS INFORMATION.**

**1.2. Online EDS Web Link**

The web link for the Online EDS is [https://webapps.cityofchicago.org/EDSWeb](https://webapps.cityofchicago.org/EDSweb)

**1.3. Online EDS Number**

Upon completion of the online EDS submission process, the Respondent will be provided an EDS number. Respondent should record this number here:

EDS Number:

**1.4. Online EDS Certification of Filing and attachment a, online eds acknowledgement**

Upon completion of the online submission process, the Respondent will be able to print a hard copy Certificate of Filing. The Respondent should submit the signed Certificate of Filing and Attachment A, Online EDS Acknowledgement form with its response. Please insert your Certification of Filing and Attachment A, Online EDS Acknowledgement form following the Cover Letter. See Section 4.2, Item I, Required Contents of Proposal in the RFP. A Respondent who does not include a signed Certificate of Filing and/or Attachment A, Online EDS Acknowledgement form with its response must provide it upon the request of the Chief Procurement Officer.

**1.5. Preparation Checklist For Registration**

To expedite and ease your registration process, we recommend that you collect the following information prior to registering for an Online EDS user account:

|  |  |
| --- | --- |
|  | 1. Invitation number, if you were provided an invitation number. |
|  | 2. EDS document from previous years, if available. |
|  | 3. Email address to correspond with the Online EDS system. |
|  | 4. Company Information: |
|  | a. Legal Name |
|  | b. FEIN/SSN |
|  | c. City of Chicago Consultant Number, if available. |
|  | d. Address and phone number information that you would like to appear on your EDS documents. |
|  | e. EDS Captain. Check for an EDS Captain in your company - this maybe the person that usually submits EDS for your company, or the first person that registers for your company. |

**1.6. Preparation Checklist For EDS Submission**

To expedite and ease your EDS submission, we recommend that you collect the following information prior to updating your EDS information online.

Items #1 through #7 are needed for both EDS information updates and contract related EDS documents:

|  |  |
| --- | --- |
|  | 1. Invitation number, if you were provided with an invitation number. |
|  | 2. Site address that is specific to this EDS. |
|  | 3. Contact that is responsible for this EDS. |
|  | 4. EDS document from previous years, if available. |
|  | 5. Ownership structure, and if applicable, owners’ company information: |
|  | a. % of ownership |
|  | b. Legal Name |
|  | c. FEIN/SSN |
|  | d. City of Chicago Vendor Number, if available. |
|  | e. Address |
|  | 6. List of directors, officers, titleholders, etc. (if applicable). |
|  | 7. For partnerships/LLC/LLP/Joint ventures, etc.: |
|  | a. List of controlling parties (if applicable). |

Items #8 and #9 are needed ONLY for contract related EDS documents:

|  |  |
| --- | --- |
|  | 8. Contract related information (if applicable): |
|  | a. City of Chicago contract package |
|  | b. Cover page of City of Chicago bid/solicitation package |
|  | c. If EDS is related to a mod, then cover page of your current contract with the City. |
|  | 9. List of subcontractors and retained parties: |
|  | a. Name |
|  | b. Address |
|  | c. Fees – Estimated or paid |

**1.7. EDS Frequently Asked Questions**

**Q: Where do I file?**

A: The web link for the Online EDS is [https://webapps.cityofchicago.org/EDSWeb](https://webapps.cityofchicago.org/EDSweb)

**Q: How do I get help?**

A: If there is a question mark on a page or next to a field, click on the question mark for help filling out the page or field. You may also consult the User Manual and the Training Videos available on the left menu.

**Q: Why do I have to submit an EDS?**

A: The Economic Disclosure Statement (EDS) is required of applicants making an application to the City for action requiring City Council, City department or other City agency approval. For example, all bidders seeking a City contract are required to submit an EDS. Through the EDS, applicants make disclosures required by State law and City ordinances and certify compliance with various laws and ordinances. An EDS is also required of certain parties related to the applicant, such as owners and controlling parties.

**Q: Who is the Applicant?**

A: “Applicant” means any entity or person making an application to the City for action requiring City Council or other City agency approval. The applicant does not include owners and parent companies.

**Q: Who is the Disclosing Party?**

A: “Disclosing Party” means any entity or person submitting an EDS. This includes owners and parent companies.

**Q: What is an entity or legal entity?**

A: “Entity’ or ‘Legal Entity” means a legal entity (for example, a corporation, partnership, joint venture, limited liability company or trust).

**Q: What is a person for purposes of the EDS?**

A: “Person” means a human being.

**Q: Who must submit an EDS?**

A. An EDS must be submitted in any of the following three circumstances:

|  |  |
| --- | --- |
| **Applicants:** | An Applicant must always file this EDS. If the Applicant is a legal entity, state the full name of that legal entity. If the Applicant is a person acting on his/her own behalf, state his/her name. |
| **Entities holding an interest:** | Whenever a legal entity has a beneficial interest (E. G. direct or indirect ownership) of more than 7.5% in the Applicant, each such legal entity must file an EDS on its own behalf. |
| **Controlling entities:** | Whenever a Disclosing Party is a general partnership, limited partnership, limited liability company, limited liability partnership or joint venture that has a general partner, managing member, manager or other entity that can control the day-to-day management of the Disclosing Party, that entity must also file an EDS on its own behalf. Each entity with a beneficial interest of more than 7.5% in the controlling entity must also file an EDS on its own behalf. |

**Q: What information is needed to submit an EDS?**

A: The information contained in the Preparation Checklist for EDS submission.

**Q: I don’t have a user ID & password. Can I still submit an Online EDS?**

A: No. You must register and create a user ID and password before submitting an Online EDS.

**Q: What information is needed to request a user ID & password for Online EDS?**

A: The information contained in the Preparation Checklist for Registration is needed to request a login for the Online EDS.

**Q: I already have a username and password from another City web site (City Web Portal, Department of Construction and Permits, Department of Consumer Services, etc.). Can I log-in the Online EDS with that account?**

A: Usually not. The Online EDS uses a user ID and password system that is shared by the Public Vehicle Advertising and Water Payment web sites. You may use a username and password from those sites by answering “Yes” to “Is this an existing City of Chicago user ID?” when registering. Other usernames and passwords will not be automatically recognized. However, you may choose to create an identical username for the Online EDS if it is not already taken.

**Q: I don’t have an email address. How do I submit an Online EDS?**

A: You cannot get an account to submit an online EDS without an email address. If you need an e-mail address, we suggest that you use a free internet email provider such as www.hotmail.com or www.yahoo.com or rnail.google.com to open an account. The City does not endorse any particular free internet email provider. Public computers are available at all Chicago Public Library branches.

**Q: I forgot my user ID. Can I register again?**

A: No. If you are the EDS Captain of your organization, please contact the Department of Procurement Services at 312-744-4900. If you are an EDS team member, contact your EDS Captain, who can look up your user ID.

**Q: Who is the EDS Captain?**

A: The EDS Captain is a person who performs certain administrative functions for an organization which files an EDS. Each organization registered with the Online EDS has at least one EDS Captain. There may be co-captains, who are all equal. EDS Captains approve new users, change contact information for an organization, and de-active accounts of employees who have left the organization. Please see the User Manual for more information.

**Q: Why do we need EDS Captains?**

A: The Online EDS is designed to be a self-service web application which allows those doing or seeking to do business with the City to perform as many routine functions as possible without City intervention. Because many organizations have multiple staff filing an EDS, the EDS Captain role allows those organizations to self-manage the contact information and users.

**Q: Who is the EDS team?**

A: The EDS team for an organization is everyone who is registered to file an EDS on behalf of the organization.

**Q: I forgot my password. What should I do?**

A: To retrieve a temporary password, click the “Forgot your password?” link on the login page. Enter your user ID that you provided when you registered your account. The system will automatically generate a temporary password and send it to you. When you log-in with your temporary password, you will be asked to create a new password.

**Q: How do I complete an Online EDS?**

A: Click on “Create New” after logging in. The Online EDS system will walk you through the EDS questions. Please see the User Manual for details.

**Q: How do I fill out a Disclosure of Retained Parties?**

A: There is no longer a separate Disclosure of Retained Parties filing. After logging in, click on “Create New”. Answer (click) “Contract” to “Is this EDS for a contract or an EDS information update?” Click “Fill out EDS”, and click on the “Retained Parties” tab. When finished, click on “Ready to Submit.”

**Q: How do I attach documents?**

A: Attachments are discouraged. If at all possible, please provide a concise explanation in the space provided in the online form. Attachments with pages of officers are not acceptable. Names of officers must be typed into the system. If you must provide an attachment for another reason, please send it to your City of Chicago contact (contract administrator or negotiator for procurements) and they will attach it for you. Documents can be sent in PDF (preferred), Word, or paper format.

**Q: Who can complete an Economic Disclosure Statement online?**

A: Any authorized representative of your business with a user ID and password can complete your EDS online. One person, such as an assistant, can fill in the information and save it, and another person can review and electronically sign the Online EDS.

**Q: What are the benefits of filing my Economic Disclosure statement electronically?**

A: Filing electronically reduces the chance of filing an incomplete EDS and speeds up the processing of contract awards. A certificate of filing can be printed at the completion of the process and inserted into your bid package. The biggest benefit for those who frequently do business with the City is that after the first EDS, each EDS is much easier to fill out because non-contract specific information is pre-filled from the last submitted EDS.

**Q: Will my information be secure?**

A: Yes. When making your internet connection to our Web Server, you will connect through a Secure Socket Layer (SSL for short) to the “Online EDS” login page. All information you type will be protected using strong encryption. Within the login page, you will provide us with a user ID, password, and secret question for user authentication, Only you will have knowledge of this unique identification information.

**Q: I am filing electronically. How do I sign my EDS?**

A: Once you have completed the EDS, you will be prompted to enter your password and answer to your secret question. Together, these will serve as your electronic signature. Although you will also print and physically sign an EDS certification of filing as a notice that your EDS was filed, your EDS is complete as a legal document with only the electronic filing.

**Q: My address has changed. How can I update my information?**

A: You must be an EDS Captain for your organization to update this. Log-in and click on “Consultant Admin, Site Administration.” Select the appropriate site and click edit.

**Q: I have more questions. How can I contact the Department of Procurement Services?**

A: Please contact the contract administrator or negotiator assigned to your solicitation or contract. You may call DPS at 312-744-4900 between 8:30 AM and 5:00 PM Central Time.

**Q: Can I save a partially complete EDS?**

A: Yes. Click “Save”. To avoid data loss, we recommend you save your work periodically while filling out your EDS.

**Q: Do I have to re-type my information each time I submit an EDS?**

A: No. The system will remember non-contract specific information from your last submitted EDS for one year. This information will be filled-in for you in your new EDS. You will have an opportunity to correct it if it has changed since your last filing. When you submit your new EDS, the information is saved and the one-year clock begins running anew.

**Q: What are the system requirements to use the Online EDS?**

A: The following are minimum requirements to use the Online EDS:

• A PDF viewer such as Adobe Reader is installed and your web browser is configured to display PDFs automatically. You may download and install Adobe Reader free at www.adobe.comlproducts/reader/

• Your web browser is set to permit running of JavaScript.

• Your web browser allows cookies to be set for this site. Please note that while we use cookies in the Online EDS, we do not use them to track personally identifiable information, so your privacy is maintained.

• Your monitor resolution is set to a minimum of 1024 x 768.

**◘**

EXHIBIT VI – B

**CHICAGO PARK DISTRICT**

**ECONOMIC DISCLOSURE STATEMENT & AFFIDAVIT**

<< attached by reference >>

EXHIBIT VI – C

**CHICAGO PUBLIC SCHOOLS**

**NOTARIZED CONTRACTOR’S DISCLOSURE FORM**

<< attached by reference >>

EXHIBIT VII – A

**CITY OF CHICAGO**

**SAMPLE PROFESSIONAL SERVICES AGREEMENT**

SAMPLE

**PROFESSIONAL SERVICES AGREEMENT**

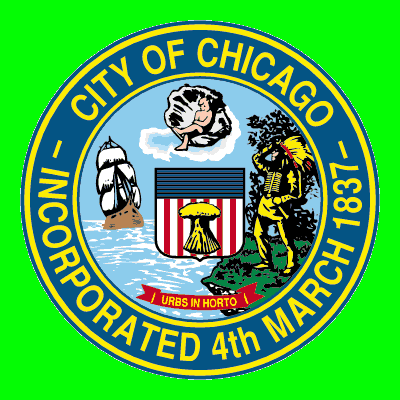
**BETWEEN**

**THE CITY OF CHICAGO**

**DEPARTMENT OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AND**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Subject of Agreement)**

**RAHM EMANUEL**

**MAYOR**

**PROFESSIONAL SERVICES AGREEMENT**

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EXHIBIT 7 LIST OF KEY PERSONNEL

[EXHIBIT 8 PROVISIONS REQUIRED IF FEDERAL FUNDS ARE INVOLVED]

**AGREEMENT**

This Agreement is entered into as of the \_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_ ("**Effective Date**") by and between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a \_\_\_\_\_\_\_\_\_\_\_\_\_\_ corporation ("**Contractor**"), and the City of Chicago, a municipal corporation and home rule unit of local government existing under the Constitution of the State of Illinois, acting through its Department of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ("**City**"), at Chicago, Illinois. The City and Contractor agree as follows:

**TERMS AND CONDITIONS**

**ARTICLE 1. DEFINITIONS**

**1.1 Definitions**

The following words and phrases have the following meanings for purposes of this Agreement:

**"Additional Services"** means those services which are within the general scope of Services of this Agreement, but beyond the description of services required under Section 2.1, and all services reasonably necessary to complete the Additional Services to the standards of performance required by this Agreement. Any Additional Services requested by the Department require the approval of the City in a written amendment under Section 9.3 of this Agreement before Contractor is obligated to perform those Additional Services and before the City becomes obligated to pay for those Additional Services.

**"Agreement"** means this Professional Services Agreement, including all exhibits attached to it and incorporated in it by reference, and all amendments, modifications or revisions made in accordance with its terms.

**"Chief Procurement Officer"** means the Chief Procurement Officer of the City and any representative duly authorized in writing to act on his behalf.

**"Commissioner"** means the Commissioner of the Department of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and any representative authorized in writing to act on the Commissioner’s behalf.

**"Department"** means the City Department of \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

"**Services**" means, collectively, the services, duties and responsibilities described in Article 2 and Exhibit 1 of this Agreement and any and all work necessary to complete them or carry them out fully and to the standard of performance required in this Agreement.

"**Subcontractor**" means any person or entity with whom Contractor contracts to provide any part of the Services, including subcontractors and subconsultants of any tier, suppliers and materials providers, whether or not in privity with Contractor.

**1.2 Interpretation**

(a) The term "**include**" (in all its forms) means "include, without limitation" unless

the context clearly states otherwise.

(b) All references in this Agreement to Articles, Sections or Exhibits, unless

otherwise expressed or indicated are to the Articles, Sections or Exhibits of this Agreement.

(c) Words importing persons include firms, associations, partnerships, trusts,

corporations and other legal entities, including public bodies, as well as natural persons.

(d) Any headings preceding the text of the Articles and Sections of this Agreement,

and any table of contents or marginal notes appended to it, are solely for convenience or reference and do not constitute a part of this Agreement, nor do they affect the meaning, construction or effect of this Agreement.

(e) Words importing the singular include the plural and vice versa. Words of the

masculine gender include the correlative words of the feminine and neuter genders.

(f) All references to a number of days mean calendar days, unless indicated

otherwise.

**1.3 Incorporation of Exhibits**

The following attached Exhibits are made a part of this Agreement:

Exhibit 1 Scope of Services and Time Limits for Performance

Exhibit 2 Schedule of Compensation

Exhibit 3 Special Conditions Regarding MBE/WBE Commitment

Exhibit 4 Economic Disclosure Statement and Affidavit

Exhibit 5 Insurance Requirements and Evidence of Insurance

Exhibit 6 Health Insurance Portability and Accountability Act

Exhibit 7 List of Key Personnel

Exhibit 8 Provisions Required If Federal Funds Are Involved

**ARTICLE 2. DUTIES AND RESPONSIBILITIES OF CONTRACTOR**

**2.1 Scope of Services**

This description of Services is intended to be general in nature and is neither a complete description of Contractor's Services nor a limitation on the Services that Contractor is to provide under this Agreement. Contractor must provide the Services in accordance with the standards of performance set forth in Section 2.3. The Services that Contractor must provide are described in Exhibit 1, Scope of Services and Time Limits for Performance.

**2.2 Deliverables**

In carrying out its Services, Contractor must prepare or provide to the City various Deliverables."**Deliverables**" include work product, such as written reviews, recommendations, reports and analyses, produced by Contractor for the City.

The City may reject Deliverables that do not include relevant information or data, or do not include all documents or other materials specified in this Agreement or reasonably necessary for the purpose for which the City made this Agreement or for which the City intends to use the Deliverables. If the City determines that Contractor has failed to comply with the foregoing standards, it has 30 days from the discovery to notify Contractor of its failure. If Contractor does not correct the failure, if it is possible to do so, within 30 days after receipt of notice from the City specifying the failure, then the City, by written notice, may treat the failure as a default of this Agreement under Section 8.1.

Partial or incomplete Deliverables may be accepted for review only when required for a specific and well-defined purpose for the benefit of the City and when consented to in advance by the City. Such Deliverables will not be considered as satisfying the requirements of this Agreement and partial or incomplete Deliverables in no way relieve Contractor of its obligations under this Agreement.

**2.3 Standard of Performance**

Contractor must perform all Services required of it under this Agreement with that degree of skill, care and diligence normally shown by a contractor performing services of a scope and purpose and magnitude comparable with the nature of the Services to be provided under this Agreement. Contractor acknowledges that it is entrusted with or has access to valuable and confidential information and records of the City and with respect to that information, Contractor agrees to be held to the standard of care of a fiduciary. **Any review, approval, acceptance of Services or Deliverables or payment for any of the Services by the City does not relieve Contractor of its responsibility for the professional skill and care and technical accuracy of its Services and Deliverables. This provision in no way limits the City's rights against Contractor under this Agreement, at law or in equity.**

Contractor must be appropriately licensed to perform the Services, if required by law, and must ensure that all Services that require the exercise of professional skills or judgment are accomplished by professionals qualified and competent in the applicable discipline and appropriately licensed as may be required by law. Contractor must provide copies of any such licenses. Contractor remains responsible for the professional and technical accuracy of all Services or Deliverables furnished, whether by Contractor or its Subcontractors or others on its behalf. All Deliverables must be prepared in a form and content satisfactory to the Department and delivered in a timely manner consistent with the requirements of this Agreement.

If Contractor fails to comply with the foregoing standards, Contractor must, at the City’s option, perform again, at its own expense, all Services required to be re-performed as a direct or indirect result of that failure, unless the reason is failure to have and maintain required licensure. See subsection 8.1 (b)(ii) regarding failure to comply with licensure requirements.

**2.4 Personnel**

(a) **Adequate Staffing**

Contractor must, upon receiving a fully executed copy of this Agreement, assign and maintain during the term of this Agreement and any extension of it an adequate staff of competent personnel that is fully equipped, licensed as appropriate, available as needed, qualified and assigned exclusively to perform the Services. Contractor must include among its staff the Key Personnel and positions as identified below. The level of staffing may be revised from time to time by notice in writing from Contractor to the City and with prior written consent of the City.

(b) **Key Personnel**

Contractor must not reassign or replace Key Personnel without the written consent of the City. "**Key Personnel**" means those job titles and the persons assigned to those positions in accordance with the provisions of this Section 2.4(b). The Department may at any time in writing notify Contractor that the City will no longer accept performance of Services under this Agreement by one or more Key Personnel listed. Upon that notice Contractor must immediately suspend the key person or persons from performing Services under this Agreement and must replace him or them in accordance with the terms of this Agreement. Key Personnel, if any, are identified in Exhibit 7.

(c) **Salaries and Wages**

Contractor and Subcontractors must pay all salaries and wages due all employees performing Services under this Agreement unconditionally and at least once a month without deduction or rebate on any account, except only for those payroll deductions that are mandatory by law or are permitted under applicable law and regulations. If in the performance of this Agreement Contractor underpays any such salaries or wages, the Comptroller for the City may withhold, out of payments due to Contractor, an amount sufficient to pay to employees underpaid the difference between the salaries or wages required to be paid under this Agreement and the salaries or wages actually paid these employees for the total number of hours worked. The amounts withheld may be disbursed by the Comptroller for and on account of Contractor to the respective employees to whom they are due. The parties acknowledge that this Section 2.4(c) is solely for the benefit of the City and that it does not grant any third party beneficiary rights.

**2.5 Minority and Women's Business Enterprises Commitment**

In the performance of this Agreement, including the procurement and lease of materials or equipment, Contractor must abide by the minority and women's business enterprise commitment requirements of the Municipal Code of Chicago (**“Municipal Code”**), §2-92-420 *et seq.* (1990), except to the extent waived by the Chief Procurement Officer and the Special Conditions Regarding MBE/WBE Commitment set forth in Exhibit 3. Contractor's completed Schedules C-1 and D-1 in Exhibit 3, evidencing its compliance with this requirement, are a part of this Agreement, upon acceptance by the Chief Procurement Officer. Contractor must utilize minority and women's business enterprises at the greater of the amounts listed in those Schedules C-1 and D-1 or the percentages listed in them as applied to all payments received from the City.

**2.6 Insurance**

Contractor must provide and maintain at Contractor's own expense, during the term of this Agreement and any time period following expiration if Contractor is required to return and perform any of the Services or Additional Services under this Agreement, the insurance coverages and requirements specified in Exhibit 5 of this Agreement, insuring all operations related to this Agreement.

**2.7 Indemnification**

(a) Contractor must defend, indemnify, and hold harmless the City, its officers,representatives, elected and appointed officials, agents and employees from and against any and all Losses, including those related to:

(i) injury, death or damage of or to any person or property;

(ii) any infringement or violation of any property right (including any patent,

trademark or copyright);

(iii) Contractor’s failure to perform or cause to be performed Contractor’s

promises and obligations as and when required under this Agreement, including Contractor’s failure to perform its obligations to any Subcontractor;

(iv) the City’s exercise of its rights and remedies under Section 8.2 of this Agreement; and

(v) injuries to or death of any employee of Contractor or any Subcontractor

under any workers compensation statute.

(b) "**Losses**" means, individually and collectively, liabilities of every kind, including losses, damages and reasonable costs, payments and expenses (such as, but not limited to, court costs and reasonable attorneys' fees and disbursements), claims, demands, actions, suits, proceedings, judgments or settlements, any or all of which in any way arise out of or relate to Contractor’s breach of this Agreement or to Contractor’s negligent or otherwise wrongful acts or omissions or those of its officers, agents, employees, consultants, Subcontractors or licensees.

(c) At the City Corporation Counsel’s option, Contractor must defend all suits

brought upon all such Losses and must pay all costs and expenses incidental to them, but the City has the right, at its option, to participate, at its own cost, in the defense of any suit, without relieving Contractor of any of its obligations under this Agreement. Any settlement must be made only with the prior written consent of the City Corporation Counsel, if the settlement requires any action on the part of the City.

(d) To the extent permissible by law, Contractor waives any limits to the amount of

its obligations to defend, indemnify, hold harmless, or contribute to any sums due under any Losses, including any claim by any employee of Contractor that may be subject to the Workers Compensation Act, 820 ILCS 305/1 *et seq*. or any other related law or judicial decision (such as, *Kotecki v. Cyclops Welding Corporation*, 146 Ill. 2d 155 (1991)). The City, however, does not waive any limitations it may have on its liability under the Illinois Workers Compensation Act, the Illinois Pension Code, any other statute or judicial decision.

(e) The indemnities in this section survive expiration or termination of this

Agreement for matters occurring or arising during the term of this Agreement or as the result of or during Contractor’s performance of Services beyond the term. Contractor acknowledges that the requirements set forth in this section to defend, indemnify, and hold harmless the City are apart from and not limited by the Contractor's duties under this Agreement, including the insurance requirements in Exhibit 5 of this Agreement.

**2.8 Ownership of Documents**

All Deliverables, data, findings or information in any form prepared, assembled or encountered by or provided to Contractor under this Agreement are property of the City, including, as further described in Section 2.9 below, all copyrights inherent in them or their preparation. During performance of its Services, Contractor is responsible for any loss or damage to the Deliverables, data, findings or information while in Contractor's or any Subcontractor's possession. Any such lost or damaged Deliverables, data, findings or information must be restored at the expense of Contractor. If not restorable, Contractor must bear the cost of replacement and of any loss suffered by the City on account of the destruction, as provided in Section 2.7.

**2.9 Copyright Ownership**

Contractor and the City intend that, to the extent permitted by law, the Deliverables to be produced by Contractor at the City's instance and expense under this Agreement are conclusively deemed "**works made for hire**" within the meaning and purview of Section 101 of the United States Copyright Act, 17 U.S.C. §101 *et seq.*, and that the City will be the sole copyright owner of the Deliverables and of all aspects, elements and components of them in which copyright can subsist, and of all rights to apply for copyright registration or prosecute any claim of infringement.

To the extent that any Deliverable does not qualify as a "work made for hire," Contractor hereby irrevocably grants, conveys, bargains, sells, assigns, transfers and delivers to the City, its successors and assigns, all right, title and interest in and to the copyrights and all U.S. and foreign copyright registrations, copyright applications and copyright renewals for them, and other intangible, intellectual property embodied in or pertaining to the Deliverables prepared for the City under this Agreement, and all goodwill relating to them, free and clear of any liens, claims or other encumbrances, to the fullest extent permitted by law. Contractor will, and will cause all of its Subcontractors, employees, agents and other persons within its control to, execute all documents and perform all acts that the City may reasonably request in order to assist the City in perfecting its rights in and to the copyrights relating to the Deliverables, at the sole expense of the City. Contractor warrants to the City, its successors and assigns, that on the date of transfer Contractor is the lawful owner of good and marketable title in and to the copyrights for the Deliverables and has the legal rights to fully assign them. Contractor further warrants that it has not assigned and will not assign any copyrights and that it has not granted and will not grant any licenses, exclusive or nonexclusive, to any other party, and that it is not a party to any other agreements or subject to any other restrictions with respect to the Deliverables. Contractor warrants that the Deliverables are complete, entire and comprehensive, and that the Deliverables constitute a work of original authorship.

**2.10 Records and Audits**

(a) **Records**

(i) Contractor must deliver or cause to be delivered to the City all documents, including all Deliverables prepared for the City under the terms of this Agreement, promptly in accordance with the time limits prescribed in this Agreement, and if no time limit is specified, then upon reasonable demand for them or upon termination or completion of the Services under this Agreement. If Contractor fails to make such delivery upon demand, then Contractor must pay to the City any damages the City may sustain by reason of Contractor’s failure.

(ii) Contractor must maintain any such records including Deliverables not delivered to the City or demanded by the City for a period that is the longer of (A) 5 years after the final payment made in connection with this Agreement (or, 6 years after the final payment made in connection with this Agreement, with respect to any records that are required to be maintained pursuant to the Contractor’s obligations under Exhibit 6 and the regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH), which was part of the American Recovery and Reinvestment Act of 2009, specifically 45 C.F.R. § 164.530(j)), or (B) as directed by the Local Records Act (50 ILCS 205) and relevant records retention schedule. Contractor must not dispose of such records following the expiration of the relevant period without notification of and written approval from the City in accordance with Article 10.

In addition to the records to be stored by Contractor, all records that are possessed by Contractor in its service to the City to perform a governmental function are public records of the City pursuant to the Illinois Freedom of Information Act (“FOIA”), unless the records are exempt under the Act. FOIA requires that the City produce records in a very short period of time. If the Contractor receives a request from the City to produce records, the Contractor shall do so within 72 hours of the notice.

(b) **Audits**

(i) Contractor and any of Contractor's Subcontractors must furnish the Department with all information that may be requested pertaining to the performance and cost of the Services. Contractor must maintain records showing actual time devoted and costs incurred. Contractor must keep books, documents, papers, records and accounts in connection with the Services open to audit, inspection, copying, abstracting and transcription and must make these records available to the City and any other interested governmental agency, at reasonable times during the performance of its Services.

(ii) To the extent that Contractor conducts any business operations separate and apart from the Services required under this Agreement using, for example, personnel, equipment, supplies or facilities also used in connection with this Agreement, then Contractor must maintain and make similarly available to the City detailed records supporting Contractor's allocation to this Agreement of the costs and expenses attributable to any such shared usages.

(iii) Contractor must maintain its books, records, documents and other evidence and adopt accounting procedures and practices sufficient to reflect properly all costs of whatever nature claimed to have been incurred and anticipated to be incurred for or in connection with the performance of this Agreement. This system of accounting must be in accordance with generally accepted accounting principles and practices, consistently applied throughout.

(iv) No provision in this Agreement granting the City a right of access to records and documents is intended to impair, limit or affect any right of access to such records and documents which the City would have had in the absence of such provisions.

(v) The City may in its sole discretion audit the records of Contractor or its

Subcontractors, or both, at any time during the term of this Agreement or within six years after the Agreement ends, in connection with the goods, work, or Services provided under this Agreement. Each calendar year or partial calendar year is considered an “audited period.” If, as a result of any such audit, it is determined that Contractor or any of its Subcontractors has overcharged the City in the audited period, the City will notify Contractor. Contractor must then promptly reimburse the City for any amounts the City has paid Contractor due to the overcharges and also some or all of the cost of the audit, as follows:

A. If the audit has revealed overcharges to the City representing less than 5% of the total value, based on the Agreement prices, of the goods, work, or Services provided in the audited period, then the Contractor must reimburse the City for 50% of the cost of the audit and 50% of the cost of each subsequent audit that the City conducts;

B. If, however, the audit has revealed overcharges to the City representing 5% or more of the total value, based on the Agreement prices, of the goods, work, or Services provided in the audited period, then Contractor must reimburse the City for the full cost of the audit and of each subsequent audit.

C. If the audit reveals that the Contractor was not paid the full amount required under the Agreement, the City will pay to the Contractor the sum equal to the amount of the deficiency.

Failure of Contractor to reimburse the City in accordance with subsection A or B above is an event of default under Section 8.1 of this Agreement, and Contractor will be liable for all of the City’s costs of collection, including any court costs and attorneys’ fees.

**2.11 Confidentiality**

(a) All Deliverables and reports, data, findings or information in any form prepared, assembled or encountered by or provided by Contractor under this Agreement are property of the City and are confidential, except as specifically authorized in this Agreement or as may be required by law. Contractor must not allow the Deliverables to be made available to any other individual or organization without the prior written consent of the City. Further, all documents and other information provided to Contractor by the City are confidential and must not be made available to any other individual or organization without the prior written consent of the City. Contractor must implement such measures as may be necessary to ensure that its staff and its Subcontractors are bound by the confidentiality provisions in this Agreement.

(b) Contractor must not issue any publicity news releases or grant press interviews, and except as may be required by law during or after the performance of this Agreement, disseminate any information regarding its Services or the project to which the Services pertain without the prior written consent of the Commissioner.

(c) If Contractor is presented with a request for documents by any administrative agency or with a subpoena duces tecum regarding any records, data or documents which may be in Contractor's possession by reason of this Agreement, Contractor must immediately give notice to the Commissioner and the Corporation Counsel for the City with the understanding that the City will have the opportunity to contest such process by any means available to it before the records, data or documents are submitted to a court or other third party. Contractor, however, is not obligated to withhold the delivery beyond the time ordered by a court or administrative agency, unless the subpoena or request is quashed or the time to produce is otherwise extended.

(d) HIPAA, HITECH, and AIDS Confidentiality Act. To the extent not defined herein the capitalized terms below and in Exhibit 6 will have the same meaning as set forth in the Health Insurance Portability and Accountability Act, the Health Information Technology for Economic and Clinical Health Act, and their implementing regulations (collectively “HIPAA”). See 45 CFR parts 160, 162 and 164. Contractor and all its Subcontractors must comply with HIPAA and all rules and regulations applicable to it or them. Contractor must also comply with the Illinois AIDS Confidentiality Act (410 ILCS 305/1 through 16) and the rules and regulations of the Illinois Department of Public Health promulgated under it. If Contractor fails to comply with the applicable provisions under HIPAA or the Illinois AIDS Confidentiality Act, such failure will constitute an event of default under this Agreement for which no opportunity for cure will be provided.

Additionally, if Contractor is a Business Associate it must comply with all requirements of the HIPAA applicable to Business Associates including the provisions contained in Exhibit 6.

**2.12 Assignments and Subcontracts**

(a) Contractor must not assign, delegate or otherwise transfer all or any part of its rights or obligations under this Agreement: (i) unless otherwise provided for elsewhere in this Agreement; or (ii) without the express written consent of the Chief Procurement Officer and the Department. The absence of such a provision or written consent voids the attempted assignment, delegation or transfer and is of no effect as to the Services or this Agreement. No approvals given by the Chief Procurement Officer, including approvals for the use of any Subcontractors, operate to relieve Contractor of any of its obligations or liabilities under this Agreement.

(b) All Subcontractors are subject to the prior approval of the Chief Procurement Officer. Approval for the use of any Subcontractor in performance of the Services is conditioned upon performance by the Subcontractor in accordance with the terms and conditions of this Agreement. If any Subcontractor fails to perform the Services in accordance with the terms and conditions of this Agreement to the satisfaction of the Department, the City has the absolute right upon written notification to immediately rescind approval and to require the performance of this Agreement by Contractor personally or through any other City-approved Subcontractor. Any approval for the use of Subcontractors in the performance of the Services under this Agreement under no circumstances operates to relieve Contractor of any of its obligations or liabilities under this Agreement.

(c) Contractor, upon entering into any agreement with a Subcontractor, must furnish upon request of the Chief Procurement Officer or the Department a copy of its agreement. Contractor must ensure that all subcontracts contain provisions that require the Services be performed in strict accordance with the requirements of this Agreement, provide that the Subcontractors are subject to all the terms of this Agreement and are subject to the approval of the Department and the Chief Procurement Officer. If the agreements do not prejudice any of the City's rights under this Agreement, such agreements may contain different provisions than are provided in this Agreement with respect to extensions of schedule, time of completion, payments, guarantees and matters not affecting the quality of the Services.

(d) Contractor must not transfer or assign any funds or claims due or to become due under this Agreement without the prior written approval of the Chief Procurement Officer. The attempted transfer or assignment of any funds, either in whole or in part, or any interest in them, which are due or to become due to Contractor under this Agreement, without such prior written approval, has no effect upon the City.

(e) Under §2-92-245 of the Municipal Code, the Chief Procurement Officer may make direct payments to Subcontractors for Services performed under this Agreement. Any such payment has the same effect as if the City had paid Contractor that amount directly. Such payment by the City to Contractor's Subcontractor under no circumstances operates to relieve Contractor of any of its obligations or liabilities under this Agreement. This section is solely for the benefit of the City and does not grant any third party beneficiary rights.

(f) The City reserves the right to assign or otherwise transfer all or any part of its interests under this Agreement to any successor.

**ARTICLE 3. DURATION OF AGREEMENT**

**3.1 Term of Performance**

This Agreement takes effect as of the Effective Date and continues, except as provided under Sections 4.4 or Article 8, until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as that date may be extended under Section 3.3.

**3.2 Timeliness of Performance**

(a) Contractor must provide the Services and Deliverables within the time limits

required under any request for services pursuant to the provisions of Section 2.1 and Exhibit 1. **Further, Contractor acknowledges that TIME IS OF THE ESSENCE and that the failure of Contractor to comply with the required time limits may result in economic or other losses to the City.**

(b) Neither Contractor nor Contractor’s agents, employees or Subcontractors are

entitled to any damages from the City, nor is any party entitled to be reimbursed by the City, for damages, charges or other losses or expenses incurred by Contractor by reason of delays or hindrances in the performance of the Services, whether or not caused by the City.

**3.3 Agreement Extension Option**

The Chief Procurement Officer may at any time before this Agreement expires elect to extend this Agreement for up to 2 years, under the same terms and conditions as this original Agreement, by notice in writing to Contractor.

**ARTICLE 4. COMPENSATION**

**4.1 Basis of Payment**

The City will pay Contractor according to the Schedule of Compensation in the attached Exhibit 2 for the completion of the Services in accordance with this Agreement, including the standard of performance in Section 2.3.

**4.2 Method of Payment**

Contractor must submit monthly invoices (in triplicate) to the City for labor and other direct costs as billed, as outlined in the Schedule of Compensation in Exhibit 2. The invoices must be in such detail as the City requests. The City will process payment within 60 days after receipt of invoices and all supporting documentation necessary for the City to verify the Services provided under this Agreement.

**4.3 Funding**

The source of funds for payments under this Agreement is Fund number . Payments under this Agreement must not exceed $ without a written amendment in accordance with Section 9.3. Funding for this Agreement is subject to the availability of funds and their appropriation by the City Council of the City.

**4.4 Non-Appropriation**

If no funds or insufficient funds are appropriated and budgeted in any fiscal period of the City for payments to be made under this Agreement, then the City will notify Contractor in writing of that occurrence, and this Agreement will terminate on the earlier of the last day of the fiscal period for which sufficient appropriation was made or whenever the funds appropriated for payment under this Agreement are exhausted. Payments for Services completed to the date of notification will be made to Contractor except that no payments will be made or due to Contractor under this Agreement beyond those amounts appropriated and budgeted by the City to fund payments under this Agreement.

**ARTICLE 5. DISPUTES**

Except as otherwise provided in this Agreement, Contractor must and the City may bring any dispute arising under this Agreement which is not resolved by the parties to the Chief Procurement Officer for decision based upon the written submissions of the parties. (A copy of the "Regulations of the Department of Procurement Services for Resolution of Disputes between Contractors and the City of Chicago" is available in City Hall, 121 N. LaSalle Street, Room 301, Bid and Bond Room, Chicago, Illinois 60602.) The Chief Procurement Officer will issue a written decision and send it to the Contractor by mail. The decision of the Chief Procurement Officer is final and binding. The sole and exclusive remedy to challenge the decision of the Chief Procurement Officer is judicial review by means of a common law writ of certiorari.

**ARTICLE 6. COMPLIANCE WITH ALL LAWS**

**6.1 Compliance with All Laws Generally**

(a) Contractor must observe and comply with all applicable federal, state, county and

municipal laws, statutes, ordinances and executive orders, in effect now or later and whether or not they appear in this Agreement, including those set forth in this Article 6, and Contractor must pay all taxes and obtain all licenses, certificates and other authorizations required by them. Contractor must require all Subcontractors to do so, also. Further, Contractor must execute an Economic Disclosure Statement and Affidavit ("**EDS**") in the form attached to this Agreement as Exhibit 4. Notwithstanding acceptance by the City of the EDS, Contractor’s failure in the EDS to include all information required under the Municipal Code renders this Agreement voidable at the option of the City. Contractor must promptly update its EDS(s) on file with the City whenever any information or response provided in the EDS(s) is no longer complete and accurate. Contractor agrees that Contractor’s failure to maintain current throughout the term and any extensions of the term, the disclosures and information pertaining to ineligibility to do business with the City under Chapter 1-23 of the Municipal Code, as such is required under Sec. 2-154-020, shall constitute an event of default.

(b) Notwithstanding anything in this Agreement to the contrary, references to a

statute or law are considered to be a reference to (i) the statute or law as it may be amended from time to time; (ii) all regulations and rules pertaining to or promulgated pursuant to the statute or law; and (iii) all future statutes, laws, regulations, rules and executive orders pertaining to the same or similar subject matter.

**6.2 Nondiscrimination**

(a) **Contractor**

Contractor must comply with applicable federal, state, and local laws and related regulations prohibiting discrimination against individuals and groups. If this Agreement is federally funded in whole or in part, additional provisions related to nondiscrimination may be set forth in Exhibit 8.

(i) **Federal Requirements**

Contractor must not engage in unlawful employment practices, such as (1) failing or refusing to hire or discharging any individual, or otherwise discriminating against any individual with respect to compensation or the terms, conditions, or privileges of the individual’s employment, because of the individual's race, color, religion, sex, age, handicap/disability or national origin; or (2) limiting, segregating or classifying Contractor’s employees or applicants for employment in any way that would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect the individual’s status as an employee, because of the individual's race, color, religion, sex, age, handicap/disability or national origin.

Contractor must comply with, and the procedures Contractor utilizes and the Services Contractor provides under this Agreement must comply with, the Civil Rights Act of 1964, 42 U.S.C. sec. 2000e *et seq*. (1981), as amended and the Civil Rights Act of 1991, P.L. 102-166. Attention is called to: Exec. Order No. 11246, 30 Fed. Reg. 12,319 (1965), reprinted in 42 U.S.C. 2000e note, as amended by Exec. Order No. 11375, 32 Fed. Reg. 14,303 (1967) and by Exec. Order No. 12086, 43 Fed. Reg. 46,501 (1978); Age Discrimination Act, 42 U.S.C. §6101-6106 (1981); Age Discrimination in Employment Act, 29 U.S.C. §621-34; Rehabilitation Act of 1973, 29 U.S.C. §793-794 (1981); Americans with Disabilities Act, 42 U.S.C. §12101 *et seq*.; 41 C.F.R. Part 60 *et seq*. (1990); and all other applicable federal statutes, regulations and other laws.

(ii) **State Requirements**

Contractor must comply with, and the procedures Contractor utilizes and the Services Contractor provides under this Agreement must comply with, the Illinois Human Rights Act, 775 ILCS 5/1-101 *et seq.* (1990), as amended and any rules and regulations promulgated in accordance with it, including the Equal Employment Opportunity Clause, 44 Ill. Admin. Code §750 Appendix A. Furthermore, Contractor must comply with the Public Works Employment Discrimination Act, 775 ILCS 10/0.01 *et seq.* (1990), as amended, and all other applicable state statutes, regulations and other laws.

(iii) **City Requirements**

Contractor must comply with, and the procedures Contractor utilizes and the Services Contractor provides under this Agreement must comply with, the Chicago Human Rights Ordinance, ch. 2-160, Section 2-160-010 *et seq.* of the Municipal Code of Chicago (1990), as amended, and all other applicable City ordinances and rules.

(b) **Subcontractors**

Contractor must incorporate all of this Section 6.2 by reference in all agreements entered into with any suppliers of materials, furnisher of services, Subcontractors of any tier, and labor organizations that furnish skilled, unskilled and craft union skilled labor, or that may provide any such materials, labor or services in connection with this Agreement. Further, Contractor must furnish and must cause each of its Subcontractor(s) to furnish such reports and information as requested by the federal, state, and local agencies charged with enforcing such laws and regulations, including the Chicago Commission on Human Relations.

**6.3 Inspector General**

It is the duty of any bidder, proposer or Contractor, all Subcontractors, every applicant for certification of eligibility for a City contract or program, and all officers, directors, agents, partners and employees of any bidder, proposer, Contractor, Subcontractor or such applicant to cooperate with the Legislative Inspector General or the Inspector General in any investigation or hearing, if applicable, undertaken pursuant to Chapters 2-55 or 2-56, respectively, of the Municipal Code. Contractor understands and will abide by all provisions of Chapters 2-55 and 2-56 of the Municipal Code. All subcontracts must inform Subcontractors of the provision and require understanding and compliance with it.

**6.4 MacBride Ordinance**

The City of Chicago through the passage of the MacBride Principles Ordinance seeks to promote fair and equal employment opportunities and labor practices for religious minorities in Northern Ireland and provide a better working environment for all citizens in Northern Ireland.

In accordance with Section 2-92-580 of the Municipal Code of the City of Chicago, if Contractor conducts any business operations in Northern Ireland, the Contractor must make all reasonable and good faith efforts to conduct any business operations in Northern Ireland in accordance with the MacBride Principles for Northern Ireland as defined in Illinois Public Act 85-1390 (1988 Ill. Laws 3220).

The provisions of this Section 6.4 do not apply to contracts for which the City receives funds administered by the United States Department of Transportation, except to the extent Congress has directed that the Department of Transportation not withhold funds from states and localities that choose to implement selective purchasing policies based on agreement to comply with the MacBride Principles for Northern Ireland, or to the extent that such funds are not otherwise withheld by the Department of Transportation.

**6.5 Business Relationships with Elected Officials**

Pursuant to MCC Sect. 2-156-030(b), it is illegal for any elected official, or any person acting at the direction of such official, to contact either orally or in writing any other City official or employee with respect to any matter involving any person with whom the elected official has any business relationship that creates a financial interest on the part of the official, or the domestic partner or spouse of the official, or from whom or which he has derived any income or compensation during the preceding twelve months or from whom or which he reasonably expects to derive any income or compensation in the following twelve months. In addition, no elected official may participate in any discussion in any City Council committee hearing or in any City Council meeting or vote on any matter involving the person with whom the elected official has any business relationship that creates a financial interest on the part of the official, or the domestic partner or spouse of the official, or from whom or which he has derived any income or compensation during the preceding twelve months or from whom or which he reasonably expects to derive any income or compensation in the following twelve months.

Violation of MCC § 2-156-030 by any elected official with respect to this contract will be grounds for termination of this contract. The term financial interest is defined as set forth in MCC Chapter 2-156.

**6.6 Chicago "Living Wage" Ordinance**

(a) Section 2‑92‑610 of the Municipal Code provides for a living wage for certain categories of workers employed in the performance of City contracts, specifically non‑City employed security guards, parking attendants, day laborers, home and health care workers, cashiers, elevator operators, custodial workers and clerical workers ("**Covered Employees**"). Accordingly, pursuant to Section 2‑92‑610 and regulations promulgated under it:

(i) If Contractor has 25 or more full‑time employees, and

(ii) If at any time during the performance of this Agreement, Contractor and/or any Subcontractor or any other entity that provides any portion of the Services (collectively "**Performing Parties**") uses 25 or more full‑time security guards, or any number of other full‑time Covered Employees, then

(iii) Contractor must pay its Covered Employees, and must ensure that all other Performing Parties pay their Covered Employees, not less than the minimum hourly rate as determined in accordance with this provision (the "**Base Wage**") for all Services performed under this Agreement.

(b) Contractor’s obligation to pay, and to ensure payment of, the Base Wage will begin at any time during the term of this Agreement when the conditions set forth in (a)(i) and (a)(ii) above are met, and will continue until the end of the term of this Agreement.

(c) As of July 1, 2014, the Base Wage is $11.93 per hour, and each July 1 thereafter, the Base Wage will be adjusted using the most recent federal poverty guidelines for a family of four as published annually by the U.S. Department of Health and Human Services, to constitute the following: the poverty guidelines for a family of four divided by 2000 hours or the current base wage, whichever is higher. The currently applicable Base Wage is available from the Department of Procurement Services. At all times during the term of this Agreement, Contractor and all other Performing Parties must pay the Base Wage (as adjusted in accordance with the above). If the payment of prevailing wages is required for Services done under this Agreement, and the prevailing wages for Covered Employees are higher than the Base Wage, then Contractor and all other Performing Parties must pay the prevailing wage rates.

(d) Contractor must include provisions in all subcontracts requiring its Subcontractors to pay the Base Wage to Covered Employees. Contractor agrees to provide the City with documentation acceptable to the Chief Procurement Officer demonstrating that all Covered Employees, whether employed by Contractor or by a Subcontractor, have been paid the Base Wage, upon the City’s request for such documentation. The City may independently audit Contractor and/or Subcontractors to verify compliance with this section. Failure to comply with the requirements of this section will be an event of default under this Agreement, and further, failure to comply may result in ineligibility for any award of a City contract or subcontract for up to 3 years.

(e) Not‑for‑Profit Corporations: If Contractor is a corporation having federal tax-exempt status under Section 501(c)(3) of the Internal Revenue Code and is recognized under Illinois not-for-profit law, then the provisions of subsections (a) through (d) above do not apply.

**6.7 Environmental Warranties and Representations**

In accordance with Section 11-4-1600(e) of the Municipal Code of Chicago, Contractor warrants and represents that it, and to the best of its knowledge, its subcontractors have not violated and are not in violation of the following sections of the Code (collectively, the Waste Sections):

7-28-390 Dumping on public way;

7-28-440 Dumping on real estate without permit;

11-4-1410 Disposal in waters prohibited;

11-4-1420 Ballast tank, bilge tank or other discharge;

11-4-1450 Gas manufacturing residue;

11-4-1500 Treatment and disposal of solid or liquid waste;

11-4-1530 Compliance with rules and regulations required;

11-4-1550 Operational requirements; and

11-4-1560 Screening requirements.

During the period while this Agreement is executory, Contractor’s or any subcontractor’s violation of the Waste Sections, whether or not relating to the performance of this Agreement, constitutes a breach of and an event of default under this Agreement, for which the opportunity to cure, if curable, will be granted only at the sole discretion of the Chief Procurement Officer. Such breach and default entitles the City to all remedies under the Agreement, at law or in equity.

This section does not limit Contractor’s and its subcontractors’ duty to comply with all applicable federal, state, county and municipal laws, statutes, ordinances and executive orders, in effect now or later, and whether or not they appear in this Agreement.

Non-compliance with these terms and conditions may be used by the City as grounds for the termination of this Agreement, and may further affect Contractor's eligibility for future contract awards.

**6.8 Prohibition on Certain Contributions**

No Contractor or any person or entity who directly or indirectly has an ownership or beneficial interest in Contractor of more than 7.5% ("Owners"), spouses and domestic partners of such Owners, Contractor’s Subcontractors, any person or entity who directly or indirectly has an ownership or beneficial interest in any Subcontractor of more than 7.5% ("Sub-owners") and spouses and domestic partners of such Sub-owners (Contractor and all the other preceding classes of persons and entities are together, the "Identified Parties"), shall make a contribution of any amount to the Mayor of the City of Chicago (the "Mayor") or to his political fundraising committee during (i) the bid or other solicitation process for this Contract or Other Contract, including while this Contract or Other Contract is executory, (ii) the term of this Contract or any Other Contract between City and Contractor, and/or (iii) any period in which an extension of this Contract or Other Contract with the City is being sought or negotiated.

Contractor represents and warrants that since the date of public advertisement of the specification, request for qualifications, request for proposals or request for information (or any combination of those requests) or, if not competitively procured, from the date the City approached the Contractor or the date the Contractor approached the City, as applicable, regarding the formulation of this Contract, no Identified Parties have made a contribution of any amount to the Mayor or to his political fundraising committee.

Contractor shall not: (a) coerce, compel or intimidate its employees to make a contribution of any amount to the Mayor or to the Mayor’s political fundraising committee; (b) reimburse its employees for a contribution of any amount made to the Mayor or to the Mayor’s political fundraising committee; or (c) bundle or solicit others to bundle contributions to the Mayor or to his political fundraising committee.

The Identified Parties must not engage in any conduct whatsoever designed to intentionally violate this provision or Mayoral Executive Order No. 2011-4 or to entice, direct or solicit others to intentionally violate this provision or Mayoral Executive Order No. 2011-4.

Violation of, non-compliance with, misrepresentation with respect to, or breach of any covenant or warranty under this provision or violation of Mayoral Executive Order No. 2011-4 constitutes a breach and default under this Contract, and under any Other Contract for which no opportunity to cure will be granted. Such breach and default entitles the City to all remedies (including without limitation termination for default) under this Contract, under Other Contract, at law and in equity. This provision amends any Other Contract and supersedes any inconsistent provision contained therein.

If Contractor violates this provision or Mayoral Executive Order No. 2011-4 prior to award of the Contract resulting from this specification, the CPO may reject Contractor’s bid.

For purposes of this provision:

"Other Contract" means any agreement entered into between the Contractor and the City that is (i) formed under the authority of MCC Ch. 2-92; (ii) for the purchase, sale or lease of real or personal property; or (iii) for materials, supplies, equipment or services which are approved and/or authorized by the City Council.

"Contribution" means a "political contribution" as defined in MCC Ch. 2-156, as amended.

"Political fundraising committee" means a "political fundraising committee" as defined in MCC Ch. 2-156, as amended.

**6.9 Firms Owned or Operated by Individuals with Disabilities**

The City encourages consultants to use Subcontractors that are firms owned or operated by individuals with disabilities, as defined by Section 2-92-586 of the Municipal Code of the City of Chicago, where not otherwise prohibited by federal or state law.

**6. 10 Ineligibility to do Business with City.**

Failure by the Contractor or any Controlling Person (defined in Section 1-23-010 of the Municipal Code) thereof to maintain eligibility to do business with the City in violation of Section 1-23-030 of the Municipal Code shall render this Contract voidable or subject to termination, at the option of the Chief Procurement Officer. Contractor agrees that Contractor's failure to maintain eligibility (or failure by Controlling Persons to maintain eligibility) to do business with the City in violation of Section 1-23-030 of the Municipal Code shall constitute an event of default.

**6.11 Duty to Report Corrupt or Unlawful Activity**

Pursuant to §2-156-018 of the Municipal Code, it is the duty of the Contractor to report to the Inspector General, directly and without undue delay, any and all information concerning conduct which it knows to involve corrupt activity. “Corrupt Activity” means any conduct set forth in Subparagraph (a)(1), (2) or (3) of §1-23-020 of the Municipal Code. Knowing failure to make such a report will be an event of default under this Agreement. Reports may be made to the Inspector General’s toll free hotline, 866-IG-TIPLINE (866-448-4754).

**6.12 Deemed Inclusion**

Provisions required by law, ordinances, rules, regulations, or executive orders to be inserted in this Agreement are deemed inserted in this Agreement whether or not they appear in this Agreement or, upon application by either party, this Agreement will be amended to make the insertion; however, in no event will the failure to insert the provisions before or after this Agreement is signed prevent its enforcement.

**ARTICLE 7. SPECIAL CONDITIONS**

**7.1 Warranties and Representations**

In connection with signing and carrying out this Agreement, Contractor:

(a) warrants that Contractor is appropriately licensed under Illinois law to perform the Services required under this Agreement and will perform no Services for which a professional license is required by law and for which Contractor is not appropriately licensed;

(b) warrants it is financially solvent; it and each of its employees, agents and Subcontractors of any tier are competent to perform the Services required under this Agreement; and Contractor is legally authorized to execute and perform or cause to be performed this Agreement under the terms and conditions stated in this Agreement;

(c) warrants that it will not knowingly use the services of any ineligible contractor or Subcontractor for any purpose in the performance of its Services under this Agreement;

(d) warrants that Contractor and its Subcontractors are not in default at the time this Agreement is signed, and have not been deemed by the Chief Procurement Officer to have, within 5 years immediately preceding the date of this Agreement, been found to be in default on any contract awarded by the City ;

(e) represents that it has carefully examined and analyzed the provisions and requirements of this Agreement; it understands the nature of the Services required; from its own analysis it has satisfied itself as to the nature of all things needed for the performance of this Agreement; this Agreement is feasible of performance in accordance with all of its provisions and requirements, and Contractor warrants it can and will perform, or cause to be performed, the Services in strict accordance with the provisions and requirements of this Agreement;

(f) represents that Contractor and, to the best of its knowledge, its Subcontractors are not in violation of the provisions of §2-92-320 of the Municipal Code , and in connection with it, and additionally in connection with the Illinois Criminal Code, 720 ILCS 5/33E as amended, and the Illinois Municipal Code, 65 ILCS 5/11-42.1-1;

(g) acknowledges that any certification, affidavit or acknowledgment made under oath in connection with this Agreement is made under penalty of perjury and, if false, is also cause for termination under Sections 8.2 and 8.3 of this Agreement; and

1. warrants and represents that neither Contractor nor an Affiliate of Contractor

(as defined below) appearson the Specially Designated Nationals List, the Denied Persons List, the unverified List, the Entity List, or the Debarred List as maintained by the Office of Foreign Assets Control of the U.S. Department of the Treasuryor by the Bureau of Industry and Security of the U.S. Department of Commerce (or their successors), or on any other list of persons or entities with which the City may not do business under any applicable law, rule, regulation, order or judgment.“Affiliate of Contractor” means a person or entity that directly (or indirectly through one or more intermediaries) controls, is controlled by or is under common control with Contractor. A person or entity will be deemed to be controlled by another person or entity if it is controlled in any manner whatsoever that results in control in fact by that other person or entity (either acting individually or acting jointly or in concert with others) whether directly or indirectly and whether through share ownership, a trust, a contract or otherwise.

**7.2 Ethics**

(a) In addition to the foregoing warranties and representations, Contractor warrants:

(i) no officer, agent or employee of the City is employed by Contractor or has a financial interest directly or indirectly in this Agreement or the compensation to be paid under this Agreement except as may be permitted in writing by the Board of Ethics established under Chapter 2-156 of the Municipal Code .

(ii) no payment, gratuity or offer of employment will be made in connection with this Agreement by or on behalf of any Subcontractors to Contractor or higher tier Subcontractors or anyone associated with them, as an inducement for the award of a subcontract or order.

(b) Contractor must comply with Chapter 2-156 of the Municipal Code. Contractor acknowledges that any Agreement entered into, negotiated or performed in violation of any of the provisions of Chapter 2-156, including any contract entered into with any person who has retained or employed a non-registered lobbyist in violation of Section 2-156-305 of the Municipal Code is voidable as to the City.

**7.3 Joint and Several Liability**

If Contractor, or its successors or assigns, if any, is comprised of more than one individual or other legal entity (or a combination of them), then under this Agreement, each and without limitation every obligation or undertaking in this Agreement to be fulfilled or performed by Contractor is the joint and several obligation or undertaking of each such individual or other legal entity.

**7.4 Business Documents**

At the request of the City, Contractor must provide copies of its latest articles of incorporation, by-laws and resolutions, or partnership or joint venture agreement, as applicable.

**7.5 Conflicts of Interest**

(a) No member of the governing body of the City or other unit of government and no

other officer, employee or agent of the City or other unit of government who exercises any functions or responsibilities in connection with the Services to which this Agreement pertains is permitted to have any personal interest, direct or indirect, in this Agreement. No member of or delegate to the Congress of the United States or the Illinois General Assembly and no alderman of the City or City employee is allowed to be admitted to any share or part of this Agreement or to any financial benefit to arise from it.

(b) Contractor represents that it, and to the best of its knowledge, its Subcontractors

if any (Contractor and Subcontractors will be collectively referred to in this Section 7.5 as "**Consulting Parties**"), presently have no direct or indirect interest and will not acquire any direct or indirect interest in any project or contract that would conflict in any manner or degree with the performance of its Services under this Agreement.

(c) Upon the request of the City, Consulting Parties must disclose to the City their past client lists and the names of any clients with whom they have an ongoing relationship. Consulting Parties are not permitted to perform any Services for the City on applications or other documents submitted to the City by any of Consulting Parties’ past or present clients. If Consulting Parties become aware of a conflict, they must immediately stop work on the assignment causing the conflict and notify the City.

(d) Without limiting the foregoing, if the Consulting Parties assist the City in

determining the advisability or feasibility of a project or in recommending, researching, preparing, drafting or issuing a request for proposals or bid specifications for a project, the Consulting Parties must not participate, directly or indirectly, as a prime, subcontractor or joint venturer in that project or in the preparation of a proposal or bid for that project during the term of this Agreement or afterwards. The Consulting Parties may, however, assist the City in reviewing the proposals or bids for the project if none of the Consulting Parties have a relationship with the persons or entities that submitted the proposals or bids for that project.

(e) Further, Consulting Parties must not assign any person having any conflicting

interest to perform any Services under this Agreement or have access to any confidential information, as described in Section 2.11 of this Agreement. If the City, by the Commissioner in his reasonable judgment, determines that any of Consulting Parties' services for others conflict with the Services that Consulting Parties are to render for the City under this Agreement, Consulting Parties must terminate such other services immediately upon request of the City.

(f) Furthermore, if any federal funds are to be used to compensate or reimburse

Contractor under this Agreement, Contractor represents that it is and will remain in compliance with federal restrictions on lobbying set forth in Section 319 of the Department of the Interior and Related Agencies Appropriations Act for Fiscal Year 1990, 31 U.S.C. §1352, and related rules and regulations set forth at 54 Fed. Reg. 52,309 ff. (1989), as amended. If federal funds are to be used, Contractor must execute a Certification Regarding Lobbying, which is part of the EDS and incorporated by reference as if fully set forth here.

**7.6 Non-Liability of Public Officials**

Contractor and any assignee or Subcontractor of Contractor must not charge any official, employee or agent of the City personally with any liability or expenses of defense or hold any official, employee or agent of the City personally liable to them under any term or provision of this Agreement or because of the City's execution, attempted execution or any breach of this Agreement.

**7.7 EDS / Certification Regarding Suspension and Debarment**

Contractor certifies, as further evidenced in the EDS attached as

Exhibit 4, by its acceptance of this Agreement that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in this transaction by any federal department or agency. Contractor further agrees by executing this Agreement that it will include this clause without modification in all lower tier transactions, solicitations, proposals, contracts and subcontracts. If Contractor or any lower tier participant is unable to certify to this statement, it must attach an explanation to the Agreement.

**ARTICLE 8. EVENTS OF DEFAULT, REMEDIES, TERMINATION,**

**SUSPENSION AND RIGHT TO OFFSET**

**8.1 Events of Default Defined**

The following constitute events of default:

(a) Any material misrepresentation, whether negligent or willful and whether in the

inducement or in the performance, made by Contractor to the City.

(b) Contractor's material failure to perform any of its obligations under this Agreement including the following:

(i) Failure to perform the Services with sufficient personnel and equipment or with sufficient material to ensure the timely performance of the Services;

(ii) Failure to have and maintain all professional licenses required by law to perform the Services;

(iii) Failure to timely perform the Services;

(iv) Failure to perform the Services in a manner reasonably satisfactory to the Commissioner or the Chief Procurement Officer or inability to perform the Services satisfactorily as a result of insolvency, filing for bankruptcy or assignment for the benefit of creditors;

(v) Failure to promptly re-perform, as required, within a reasonable time and at no cost to the City, Services that are rejected as erroneous or unsatisfactory;

(vi) Discontinuance of the Services for reasons within Contractor's reasonable control;

(vii) Failure to comply with Section 6.1 in the performance of the Agreement;

(viii) Failure promptly to update EDS(s) furnished in connection with this Agreement when the information or responses contained in it or them is no longer complete or accurate;

(ix) Failure to comply with any other material term of this Agreement, including the provisions concerning insurance and nondiscrimination; and

(x) Any other acts specifically stated in this Agreement as constituting an act

of default.

(c) Any change in ownership or control of Contractor without the prior written approval of the Chief Procurement Officer (when such prior approval is permissible by law), which approval the Chief Procurement Officer will not unreasonably withhold.

(d) Contractor's default under any other agreement it may presently have or may

enter into with the City for the duration of this Agreement. Contractor acknowledges that in the event of a default under this Agreement the City may also declare a default under any such other agreements.

(e) Contractor’s violation of City ordinance(s) unrelated to performance under the

Agreement such that, in the opinion of the Chief Procurement Officer, it indicates a willful or reckless disregard for City laws and regulations.

**8.2 Remedies**

(a) Notices. The occurrence of any event of default permits the City, at the City’s sole option, to declare Contractor in default. The Chief Procurement Officer may in his sole discretion give Contractor an opportunity to cure the default within a certain period of time, which period of time must not exceed 30 days unless extended by the Chief Procurement Officer. Whether to declare Contractor in default is within the sole discretion of the Chief Procurement Officer and neither that decision nor the factual basis for it is subject to review or challenge under the Disputes provision of this Agreement.

The Chief Procurement Officer will give Contractor written notice of the default, either in the form of a cure notice ("**Cure Notice**"), or, if no opportunity to cure will be granted, a default notice ("**Default Notice**"). If the Chief Procurement Officer gives a Default Notice, he will also indicate any present intent he may have to terminate this Agreement, and the decision to terminate is final and effective upon giving the notice. If the Chief Procurement Officer decides not to terminate, this decision will not preclude him from later deciding to terminate the Agreement in a later notice, which will be final and effective upon the giving of the notice or on the date set forth in the notice, whichever is later. The Chief Procurement Officer may give a Default Notice if Contractor fails to effect a cure within the cure period given in a Cure Notice. When a Default Notice with intent to terminate is given as provided in this Section 8.2 and Article 10, Contractor must discontinue any Services, unless otherwise directed in the notice, and deliver all materials accumulated in the performance of this Agreement, whether completed or in the process, to the City.

(b) Exercise of Remedies. After giving a Default Notice, the City may invoke any or all of the following remedies:

(i) The right to take over and complete the Services, or any part of them, at Contractor’s expense and as agent for Contractor, either directly or through others, and bill Contractor for the cost of the Services, and Contractor must pay the difference between the total amount of this bill and the amount the City would have paid Contractor under the terms and conditions of this Agreement for the Services that were assumed by the City as agent for Contractor under this Section 8.2;

(ii) The right to terminate this Agreement as to any or all of the Services yet to be performed effective at a time specified by the City;

(iii) The right of specific performance, an injunction or any other appropriate equitable remedy;

(iv) The right to money damages;

(v) The right to withhold all or any part of Contractor's compensation under

this Agreement;

(vi) The right to deem Contractor non-responsible in future contracts to be

awarded by the City;

(vii) The right to declare default on any other contract or agreement Contractor

may have with the City.

(c) City’s Reservation of Rights. If the Chief Procurement Officer considers it to be in the City’s best interests, he may elect not to declare default or to terminate this Agreement. The parties acknowledge that this provision is solely for the benefit of the City and that if the City permits Contractor to continue to provide the Services despite one or more events of default, Contractor is in no way relieved of any of its responsibilities, duties or obligations under this Agreement, nor does the City waive or relinquish any of its rights.

(d) Non-Exclusivity of Remedies. The remedies under the terms of this Agreement are not intended to be exclusive of any other remedies provided, but each and every such remedy is cumulative and is in addition to any other remedies, existing now or later, at law, in equity or by statute. No delay or omission to exercise any right or power accruing upon any event of default impairs any such right or power, nor is it a waiver of any event of default nor acquiescence in it, and every such right and power may be exercised from time to time and as often as the City considers expedient.

**8.3 Early Termination**

(a) In addition to termination under Sections 8.1 and 8.2 of this Agreement, the City may terminate this Agreement, or all or any portion of the Services to be performed under it, at any time by a notice in writing from the City to Contractor. The City will give notice to Contractor in accordance with the provisions of Article 10. The effective date of termination will be the date the notice is received by Contractor or the date stated in the notice, whichever is later. If the City elects to terminate this Agreement in full, all Services to be provided under it must cease and all materials that may have been accumulated in performing this Agreement, whether completed or in the process, must be delivered to the City effective 10 days after the date the notice is considered received as provided under Article 10 of this Agreement (if no date is given) or upon the effective date stated in the notice.

(b) After the notice is received, Contractor must restrict its activities, and those of its Subcontractors, to winding down any reports, analyses, or other activities previously begun. No costs incurred after the effective date of the termination are allowed. Payment for any Services actually and satisfactorily performed before the effective date of the termination is on the same basis as set forth in Article 4, but if any compensation is described or provided for on the basis of a period longer than 10 days, then the compensation must be prorated accordingly. No amount of compensation, however, is permitted for anticipated profits on unperformed Services. The City and Contractor must attempt to agree on the amount of compensation to be paid to Contractor, but if not agreed on, the dispute must be settled in accordance with Article 5 of this Agreement. The payment so made to Contractor is in full settlement for all Services satisfactorily performed under this Agreement.

(c) Contractor must include in its contracts with Subcontractors an early termination provision in form and substance equivalent to this early termination provision to prevent claims against the City arising from termination of subcontracts after the early termination. Contractor will not be entitled to make any early termination claims against the City resulting from any Subcontractor’s claims against Contractor or the City.

(d) If the City's election to terminate this Agreement for default under Sections 8.1 and 8.2 is determined in a court of competent jurisdiction to have been wrongful, then in that case the termination is to be considered to be an early termination under this Section 8.3.

**8.4 Suspension**

The City may at any time request that Contractor suspend its Services, or any part of them, by giving 15 days prior written notice to Contractor or upon informal oral, or even no notice, in the event of emergency. No costs incurred after the effective date of such suspension are allowed. Contractor must promptly resume its performance of the Services under the same terms and conditions as stated in this Agreement upon written notice by the Chief Procurement Officer and such equitable extension of time as may be mutually agreed upon by the Chief Procurement Officer and Contractor when necessary for continuation or completion of Services. Any additional costs or expenses actually incurred by Contractor as a result of recommencing the Services must be treated in accordance with the compensation provisions under Article 4 of this Agreement.

No suspension of this Agreement is permitted in the aggregate to exceed a period of 45 days within any one year of this Agreement. If the total number of days of suspension exceeds 45 days, Contractor by written notice to the City may treat the suspension as an early termination of this Agreement under Section 8.3.

**8.5 Right to Offset**

(a) In connection with Contractor’s performance under this Agreement, the City may offset any incremental costs and other damages the City incurs in any or all of the following circumstances:

(i) if the City terminates this Agreement for default or any other reason resulting from Contractor’s performance or non-performance;

(ii) if the City exercises any of its remedies under Section 8.2 of this Agreement;

(iii) if the City has any credits due or has made any overpayments under this Agreement.

The City may offset these incremental costs and other damages by use of any payment due for Services completed before the City terminated this Agreement or before the City exercised any remedies. If the amount offset is insufficient to cover those incremental costs and other damages, Contractor is liable for and must promptly remit to the City the balance upon written demand for it. This right to offset is in addition to and not a limitation of any other remedies available to the City.

(b) As provided under 2-92-380 of the Municipal Code, the City may set off from Contractor’s compensation under this Agreement an amount equal to the amount of the fines and penalties for each *outstanding parking violation complaint* and the amount of any *debt* owed by Contractor to the City as those italicized terms are defined in the Municipal Code.

(c) In connection with any liquidated or unliquidated claims against Contractor, and without breaching this Agreement, the City may set off a portion of the price or compensation due under this Agreement in an amount equal to the amount of any liquidated or unliquidated claims that the City has against Contractor unrelated to this Agreement. When the City’s claims against Contractor are finally adjudicated in a court of competent jurisdiction or otherwise resolved, the City will reimburse Contractor to the extent of the amount the City has offset against this Agreement inconsistently with such determination or resolution.

**ARTICLE 9. GENERAL CONDITIONS**

**9.1 Entire Agreement**

(a) **General**

This Agreement, and the exhibits attached to it and incorporated in it, constitute the entire agreement between the parties and no other terms, conditions, warranties, inducements, considerations, promises or interpretations are implied or impressed upon this Agreement that are not addressed in this Agreement.

(b) **No Collateral Agreements**

Contractor acknowledges that, except only for those representations, statements or promises contained in this Agreement and any exhibits attached to it and incorporated by reference in it, no representation, statement or promise, oral or in writing, of any kind whatsoever, by the City, its officials, agents or employees, has induced Contractor to enter into this Agreement or has been relied upon by Contractor, including any with reference to: (i) the meaning, correctness, suitability or completeness of any provisions or requirements of this Agreement; (ii) the nature of the Services to be performed; (iii) the nature, quantity, quality or volume of any materials, equipment, labor and other facilities needed for the performance of this Agreement; (iv) the general conditions which may in any way affect this Agreement or its performance; (v) the compensation provisions of this Agreement; or (vi) any other matters, whether similar to or different from those referred to in (i) through (vi) immediately above, affecting or having any connection with this Agreement, its negotiation, any discussions of its performance or those employed or connected or concerned with it.

(c) **No Omissions**

Contractor acknowledges that Contractor was given ample opportunity and time and was requested by the City to review thoroughly all documents forming this Agreement before signing this Agreement in order that it might request inclusion in this Agreement of any statement, representation, promise or provision that it desired or on that it wished to place reliance. Contractor did so review those documents, and either every such statement, representation, promise or provision has been included in this Agreement or else, if omitted, Contractor relinquishes the benefit of any such omitted statement, representation, promise or provision and is willing to perform this Agreement in its entirety without claiming reliance on it or making any other claim on account of its omission.

**9.2 Counterparts**

This Agreement is comprised of several identical counterparts, each to be fully signed by the parties and each to be considered an original having identical legal effect.

**9.3 Amendments**

Except as provided in Section 3.3 of this Agreement, no changes, amendments, modifications or discharge of this Agreement, or any part of it are valid unless in writing and signed by the authorized agent of Contractor and by the Mayor, Comptroller, and Chief Procurement Officer of the City or their respective successors and assigns. The City incurs no liability for Additional Services without a written amendment to this Agreement under this Section 9.3.

Whenever under this Agreement Contractor is required to obtain the City’s prior written approval, the effect of any approval that may be granted pursuant to Contractor's request is prospective only from the later of the date approval was requested or the date on which the action for which the approval was sought is to begin. In no event is approval permitted to apply retroactively to a date before the approval was requested.

**9.4 Governing Law and Jurisdiction**

This Agreement is governed as to performance and interpretation in accordance with the laws of the State of Illinois.

Contractor irrevocably submits itself to the original jurisdiction of those courts located within the County of Cook, State of Illinois, with regard to any controversy arising out of, relating to, or in any way concerning the execution or performance of this Agreement. Service of process on Contractor may be made, at the option of the City, either by registered or certified mail addressed to the applicable office as provided for in this Agreement, by registered or certified mail addressed to the office actually maintained by Contractor, or by personal delivery on any officer, director, or managing or general agent of Contractor. If any action is brought by Contractor against the City concerning this Agreement, the action must be brought only in those courts located within the County of Cook, State of Illinois.

**9.5 Severability**

If any provision of this Agreement is held or deemed to be or is in fact invalid, illegal, inoperative or unenforceable as applied in any particular case in any jurisdiction or in all cases because it conflicts with any other provision or provisions of this Agreement or of any constitution, statute, ordinance, rule of law or public policy, or for any other reason, those circumstances do not have the effect of rendering the provision in question invalid, illegal, inoperative or unenforceable in any other case or circumstances, or of rendering any other provision or provisions in this Agreement invalid, illegal, inoperative or unenforceable to any extent whatsoever. The invalidity, illegality, inoperativeness or unenforceability of any one or more phrases, sentences, clauses or sections in this Agreement does not affect the remaining portions of this Agreement or any part of it.

**9.6 Assigns**

All of the terms and conditions of this Agreement are binding upon and inure to the benefit of the parties and their respective legal representatives, successors and assigns.

**9.7 Cooperation**

Contractor must at all times cooperate fully with the City and act in the City's best interests. If this Agreement is terminated for any reason, or if it is to expire on its own terms, Contractor must make every effort to ensure an orderly transition to another provider of the Services, if any, orderly demobilization of its own operations in connection with the Services, uninterrupted provision of Services during any transition period and must otherwise comply with the reasonable requests and requirements of the Department in connection with the termination or expiration. Following termination or expiration of this Agreement, rights and obligations that by their nature should survive or which this Agreement expressly states will survive will remain in full force and effect.

**9.8 Waiver**

Nothing in this Agreement authorizes the waiver of a requirement or condition contrary to law or ordinance or that would result in or promote the violation of any federal, state or local law or ordinance.

Whenever under this Agreement the City by a proper authority waives Contractor's performance in any respect or waives a requirement or condition to either the City's or Contractor's performance, the waiver so granted, whether express or implied, only applies to the particular instance and is not a waiver forever or for subsequent instances of the performance, requirement or condition. No such waiver is a modification of this Agreement regardless of the number of times the City may have waived the performance, requirement or condition. Such waivers must be provided to Contractor in writing.

**9.9 Independent Contractor**

(a) This Agreement is not intended to and does not constitute, create, give rise to, or otherwise recognize a joint venture, partnership, corporation or other formal business association or organization of any kind between Contractor and the City. The rights and the obligations of the parties are only those set forth in this Agreement. Contractor must perform under this Agreement as an independent contractor and not as a representative, employee, agent,

or partner of the City.

(b) This Agreement is between the City and an independent contractor and, if Contractor is an individual, nothing provided for under this Agreement constitutes or implies an employer-employee relationship such that:

(i) The City will not be liable under or by reason of this Agreement for the payment of any compensation award or damages in connection with the Contractor performing the Services required under this Agreement.

(ii) Contractor is not entitled to membership in any City Pension Fund, Group Medical Insurance Program, Group Dental Program, Group Vision Care, Group Life Insurance Program, Deferred Income Program, vacation, sick leave, extended sick leave, or any other benefits ordinarily provided to individuals employed and paid through the regular payrolls of the City.

(iii) The City is not required to deduct or withhold any taxes, FICA or other deductions from any compensation provided to Contractor.

(c)(i) The City is subject to June 24, 2011 the “City of Chicago Hiring Plan” (the “City Hiring Plan”) entered in Shakman v. Democratic Organization of Cook County, Case No 69 C 2145 (United State District Court for the Northern District of Illinois). Among other things, the City Hiring Plan prohibits the City from hiring persons as governmental employees in non-exempt positions on the basis of political reasons or factors.

(ii) Contractor is aware that City policy prohibits City employees from directing any individual to apply for a position with Contractor, either as an employee or as a subcontractor, and from directing Contractor to hire an individual as an employee or as a subcontractor. Accordingly, Contractor must follow its own hiring and contracting procedures, without being influenced by City employees. Any and all personnel provided by Contractor under this Agreement are employees or subcontractors of Contractor, not employees of the City of Chicago. This Agreement is not intended to and does not constitute, create, give rise to, or otherwise recognize an employer-employee relationship of any kind between the City and any personnel provided by Contractor.

(iii) Contractor will not condition, base, or knowingly prejudice or affect any term or aspect of the employment of any personnel provided under this Agreement, or offer employment to any individual to provide services under this Agreement, based upon or because of any political reason or factor, including, without limitation, any individual’s political affiliation, membership in a political organization or party, political support or activity, political financial contributions, promises of such political support, activity or financial contributions, or such individual’s political sponsorship or recommendation. For purposes of this Agreement, a political organization or party is an identifiable group or entity that has as its primary purpose the support of or opposition to candidates for elected public office. Individual political activities are the activities of individual persons in support of or in opposition to political organizations or parties or candidates for elected public office.

(iv) In the event of any communication to Contractor by a City employee or City official in violation of Section (ii) above, or advocating a violation of Section (iii) above, Contractor will, as soon as is reasonably practicable, report such communication to the Hiring Oversight Section of the City’s Office of the Inspector General, and also to the head of the relevant City Department utilizing services provided under this Agreement. Contractor will also cooperate with any inquiries by OIG Hiring Oversight related to the contract.

(d) The parties agree that this Contract is solely for the benefit of the parties and nothing herein is intended to create any third party beneficiary rights for subcontractors or other third parties.

**ARTICLE 10. NOTICES**

Notices provided for in this Agreement, unless provided for otherwise in this Agreement, must be given in writing and may be delivered personally or by placing in the United States mail, first class and certified, return receipt requested, with postage prepaid and addressed as follows:

If to the City: Department of Finance

Room 700, City Hall

121 North LaSalle Street

Chicago, Illinois 60602

Attention: City Comptroller

With Copies to: Department of Law

Room 600, City Hall

121 North LaSalle Street

Chicago, Illinois 60602

Attention: Corporation Counsel

If to Contractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attention:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Changes in these addresses must be in writing and delivered in accordance with the provisions of this Article 10. Notices delivered by mail are considered received three days after mailing in accordance with this Article 10. Notices delivered personally are considered effective upon receipt. Refusal to accept delivery has the same effect as receipt.

**ARTICLE 11. AUTHORITY**

Execution of this Agreement by Contractor is authorized by a resolution of its Board of Directors, if a corporation, or similar governing document, and the signature(s) of each person signing on behalf of Contractor have been made with complete and full authority to commit Contractor to all terms and conditions of this Agreement, including each and every representation, certification and warranty contained in it, including the representations, certifications and warranties collectively incorporated by reference in it.

*[Signature Pages, Exhibits and Schedules follow.]*

**SIGNATURE PAGE(S)**

**SIGNED at Chicago, Illinois:**

CITY OF CHICAGO

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mayor

Recommended By:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City of Chicago Benefits Committee

CONTRACTOR[[1]](#footnote-2)

By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Its:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attest:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State of

County of

This instrument was acknowledged before me on (date) by (name/s of person/s) as (type of authority, e.g., officer, trustee, etc.) of (name of party on behalf of whom instrument was executed).

(Signature of Notary Public) Seal:

EXHIBIT VII - B

**CHICAGO PARK DISTRICT**

**SAMPLE AGREEMENT TERMS AND CONDITIONS**

<< attached by reference >>

EXHIBIT VII - C

**CHICAGO PUBLIC SCHOOLS**

**SAMPLE AGREEMENT TERMS AND CONDITIONS**

**To Be Determined**

EXHIBIT VIII – A

**CITY OF CHICAGO**

**CENSUS DATA**

**CONFIDENTIAL CD**

<< attached by reference >>

EXHIBIT VIII – B

**CHICAGO PARK DISTRICT**

**CENSUS DATA**

**CONFIDENTIAL CD**

<< attached by reference >>

EXHIBIT VIII – C

**CHICAGO PUBLIC SCHOOLS**

**CENSUS DATA**

**CONFIDENTIAL CD**

<< attached by reference >>

EXHIBIT IX

**AGENCIES’ LIST OF CURRENT MEDICAL PRACTICE GROUPS**

| **Count** | **Medical Practice Groups** | **Address** | **Zip** |
| --- | --- | --- | --- |
| 1 | Access Community Health Network | 600 Fulton | 60661 |
| 2 | Advanced Physician's Association | 2200 E 93rd St | 60617-0000 |
| 3 | Advanced Unified Physicians Network | 5215 Old Orchard Rd | 60077 |
| 4 | Advocate Christ Hospital Physician Partners | 1701 Golf Rd | 60008 |
| 5 | Advocate Condell Physician Partners | 1701 Golf Rd | 60008 |
| 6 | Advocate Good Samaritan Physician Partners | 1701 Golf Rd | 60008 |
| 7 | Advocate Good Shepherd Physician Partners | 1701 Golf Rd | 60008 |
| 8 | Advocate Illinois Masonic Physician Partners | 1701 Golf Rd | 60008 |
| 9 | Advocate Lutheran General Physician Partners | 1701 Golf Rd | 60008 |
| 10 | Advocate MG Beverly | 9831 S Western Ave | 60646 |
| 11 | Advocate MG Burbank | 4901 W 79th St | 60459 |
| 12 | Advocate MG Evergreen | 1357 W 103rd St | 60643 |
| 13 | Advocate MG Halsted and Blackhawk | 1460 N Halsted St | 60642 |
| 14 | Advocate MG Irving and Western | 4025 N Western Ave | 60618 |
| 15 | Advocate MG Logan Square | 2511 N Kedzie Ave | 60647 |
| 16 | Advocate MG North Ave Oak Park | 6434 North Ave | 60639 |
| 17 | Advocate MG Orland Square | 29 Orland Square Dr | 60462 |
| 18 | Advocate MG Palos | 7620 W 111th St | 60645 |
| 19 | Advocate MG Six Corners/Ravenswood | 1945 W Wilson Ave | 60640 |
| 20 | Advocate MG South Holland | 80 River Oaks Dr | 60409 |
| 21 | Advocate MG Southeast | 2301 E 93rd St | 60617 |
| 22 | Advocate MG Sykes | 2545 S Dr Martin Luther King Dr | 60616 |
| 23 | Advocate Sherman Physician Partners | 1701 W Golf Rd | 60008 |
| 24 | Advocate South Suburban Physician Partners | 1701 Golf Rd | 60008 |
| 25 | Advocate Trinity Physician Partners | 1701 Golf Rd | 60008 |
| 26 | Affiliated Physicians Group LLC | 18410 S Crossing Dr | 60487 |
| 27 | Alexian Bros Clinically Integrated Network | 630 E Jefferson St | 61107 |
| 28 | Alternative Medicine Integration of Illinois, LLC | 5215 Old Orchard Rd | 60077 |
| 29 | Ambay Health Network | 4527 N Pulaski Rd | 60630 |
| 30 | Cadence Medical Partners - CentralDuPage Hospital | 2001 Gary Ave | 60187 |
| 31 | Cadence Medical Partners, LLC - Delnor | 2001 Gary Ave | 60187 |
| 32 | Calumet Physicians Associates LTD | 67 W 111th St | 60628-0000 |
| 33 | Centegra Health and Wellness Network | 4209 W Shamrock Ln | 60050 |
| 34 | Century P H O | 1029 N Sacramento Ave | 60622 |
| 35 | DMG Health Partners | 1100 W 31st St | 60515 |
| 36 | Dolton Medical Associates | 1851 S. Sibley Blvd | 60409 |
| 37 | Dreyer Medical Clinic Advocate | 1870 W Galena Blvd | 60506 |
| 38 | Edward Health Partners | 1100 W 31st St | 60515 |
| 39 | Elmhurst Health Partners | 1100 W 31st St | 60515 |
| 40 | Fox Valley Medicine LTD | 37W002 Mooseheart Rd | 60539 |
| 41 | Franciscan Hammond Clinic LLC | 7905 Calumet Ave | 46321 |
| 42 | Gottlieb PHO | 675 W North Ave | 60160-1634 |
| 43 | Health Options Of Illinois IPA | 4415 W Harrison St | 60162 |
| 44 | Health Plus Physicians Organization | 475 N Martingale Rd | 60173 |
| 45 | HealthSelect IPA | 18410 S Crossing Dr | 60477 |
| 46 | Hinsdale Physicians Health Care Association INC | 4415 W Harrison St | 60162 |
| 47 | HSHS Medical Group Inc | 4936 LaVerna Rd | 62707-9797 |
| 48 | Independent Physicians At Mercy | 2525 S Michigan Ave | 60616 |
| 49 | Ingalls Provider Group | One Ingalls Dr | 60426 |
| 50 | Innovative Physicians Associates | 4415 W Harrison | 60126 |
| 51 | Kane County IPA | 143 Lincoln Ave | 60505 |
| 52 | Lake County Physicians Association | 2615 Washington St | 60085 |
| 53 | Lawndale Christian Health Center | 3860 W Ogden Ave | 60623-2460 |
| 54 | Little Company of Mary Health Providers | 18410 S Crossing Dr | 60487 |
| 55 | Loyola University Physician Foundation | 2160 S First Ave | 60153 |
| 56 | MacNeal Health Providers | 750 Pasquinelli Dr | 60559 |
| 57 | Managed Health Care Associates, Ltd. | 2740 W Foster Ave | 60625-3532 |
| 58 | Medical Care Group | 701 Lee St | 60016 |
| 59 | Mercy Physician Association | 3430 Palmer Dr | 53547 |
| 60 | Methodist First Choice | 120 NE Glen Oak Ave | 61603 |
| 61 | NorthShore MG IPA | c/o Valence Health 600 W Jackson Blvd | 60661 |
| 62 | NorthShore Physician Associates | c/o Valence Health 600 W Jackson Blvd | 60661 |
| 63 | Northwest Community Health Partners | 675 W Central Rd STE 200 | 60005-0000 |
| 64 | Northwest Primary Care Alliance | 1786 Moon Lake Blvd | 60194 |
| 65 | Northwestern Health Care Corp NHC | 630 E Jefferson St | 61107-4026 |
| 66 | Northwestern Medical Faculty Foundation | 630 E Jefferson St | 61107-4026 |
| 67 | O S F Healthcare North | 9951 Rock Cut Crossing | 61111 |
| 68 | Oak West Primary Physicians Association | 4415 W Harrison St | 60162 |
| 69 | OSF Healthcare Central | 800 NE Glen Oak | 61603 |
| 70 | P E F Clinic LTD | 2850 S Wabash Ave | 60616 |
| 71 | Partners In Health, Inc. | 326 W 64th St | 60621 |
| 72 | Physicians Care Network, INC. | 630 E Jefferson St | 61107 |
| 73 | Physicians Health Association Of Illinois | 630 E Jefferson St | 61107 |
| 74 | Presence Resurrection | 7435 W Talcott | 60631 |
| 75 | Presence St Francis | 2380 E Dempster St | 60016 |
| 76 | PRESENCE ST JOSEPH H P JOLIET | 2380 E Dempster Street | 60016 |
| 77 | Presence St Josephs | 2380 E Dempster St | 60016 |
| 78 | Presence St Mary & Elizabeth | 2380 E Dempster St | 60016 |
| 79 | Primary Care Joliet | 2025 S Chicago St | 60436 |
| 80 | Progress Health | 2701 W 68th St | 60629 |
| 81 | Pronger Smith MedicalCare | 17495 La Grange Rd | 60487 |
| 82 | Ravenswood Physicians Associates | 4100 N Lincoln Ave | 60618 |
| 83 | Resurrection Phys Provider Group | 5860 W Higgins Ave | 60630 |
| 84 | Silver Cross Managed Care Organization | 1200 W Maple Rd | 60432 |
| 85 | Sinai Medical Group | 3109 W Armitage Ave | 60647 |
| 86 | Southern Illinois Health Care Association | 531 Vandalia St | 62234 |
| 87 | Southland IPA | 8501 W 191st Street | 60448 |
| 88 | Southwest Physicians Group LTD | 4861 W 95th St | 60453 |
| 89 | St Anthony Health Network | 7905 S Calumet Ave | 4646321307 |
| 90 | St. Francis Health Care LTD | 6677 N Lincoln Ave | 60712-3634 |
| 91 | St. James PHO INC | 30 E 15th St | 60411 |
| 92 | Thorek Family Health Network | 5215 Old Orchard Rd | 60077 |
| 93 | U I C Physician Group | 820 S Wood St STE W310 | 60612 |
| 94 | Unified Physicians Network | 5215 Old Orchard Rd | 60077 |
| 95 | Weiss Healthcare System PHO | 4100 N Lincoln Ave | 60618 |
| 96 | Weiss Physician Group | 750 Pasquinelli Dr | 60559 |
| 97 | West Suburban Health Providers | PO Box 9237 | 60522-9237 |
| end |  |  |  |

EXHIBIT X

**AGENCIES’ MEDICAL SERVICES LISTING**

for use in responding to Interrogatives, Compensation Section, Question #9

**If not in capitation, what is basis of payment?\***

**SEE NOTE BELOW ON COMPLETION OF THIS ITEM**

| **Item** | **Medical Service** | **Included in Capitation?** | | **Comment** |
| --- | --- | --- | --- | --- |
| **Check √ if  YES** | **Check √ if  NO** |
| 1 | Inpatient professional services |  |  |  |
| 2 | Outpatient professional services |  |  |  |
| 3 | Wellness services professional |  |  |  |
| 4 | In-area Emergency Room Services professional |  |  |  |
| 5 | Chemical dependency/substance abuse professional services |  |  |  |
| 6 | Mental health professional services |  |  |  |
| 7 | Dental professional fees for accidental injury to sound natural teeth |  |  |  |
| 8 | Anesthesia charges for non-covered dental services if medical condition requires sedation |  |  |  |
| 9 | Outpatient diagnostic testing regardless of place of service |  |  |  |
| 10 | Outpatient rehabilitation services (PT/OT/ST) regardless of place of services |  |  |  |
| 11 | Medical supplies issued by MD office |  |  |  |
| 12 | Injections as required to be covered by plan of benefit |  |  |  |
| 13 | Immunizations in accordance with PPACA requirements |  |  |  |
| 14 | Outpatient radiation and Chemotherapy (including cost of pharmacy) regardless of place of service |  |  |  |
| 15 | Outpatient inhalation therapy regardless of place of service |  |  |  |
| 16 | Outpatient hearing screening |  |  |  |
| 17 | Outpatient ancillary services (lab, pharmacy, x-ray) performed without a surgery or inpatient stay |  |  |  |
| 18 | Outpatient treatment--any treatment performed without a surgery or inpatient stay |  |  |  |
| 19 | MD directed out of network care |  |  |  |
| 20 | Skilled Home Health care |  |  |  |
| 21 | Durable Medical Equipment (DME) |  |  |  |
| 22 | ART/Infertility |  |  |  |
| 23 | Out-patient dialysis |  |  |  |
| 24 | Orthotics |  |  |  |
| 25 | Prosthetics |  |  |  |
| 26 | In-patient hospital care other than professional fees |  |  |  |
| 27 | Emergency room charges other than professional fees |  |  |  |
| 28 | Out-patient hospital charges other than professional fees |  |  |  |
| 29 | In-patient treatment for substance use/mental health disorders other than professional fees |  |  |  |
| 30 | Partial Hospitalization and Individual Out-Patient (IOP) for substance use/mental health disorders other than professional fees |  |  |  |
|  |  |  |  |  |

**\*If the basis of payment is fee for service, please indicate whether you have discounted arrangements in place for service, and if so, provide an estimate of the expected cost to the plan as a percent of Medicare or another reasonable estimate of savings from billed charges.**

EXHIBIT XI

**AGENCIES’ LIST OF PROVIDER GROUPS**

| **Count** | **Provider Groups** | **Address** | **Zip** |
| --- | --- | --- | --- |
| 1 | Access Community Health Network | 600 Fulton | 60661 |
| 2 | Advanced Physician's Association | 2200 E 93rd St | 60617-0000 |
| 3 | Advanced Unified Physicians Network | 5215 Old Orchard Rd | 60077 |
| 4 | Advocate Christ Hospital Physician Partners | 1701 Golf Rd | 60008 |
| 5 | Advocate Condell Physician Partners | 1701 Golf Rd | 60008 |
| 6 | Advocate Good Samaritan Physician Partners | 1701 Golf Rd | 60008 |
| 7 | Advocate Good Shepherd Physician Partners | 1701 Golf Rd | 60008 |
| 8 | Advocate Illinois Masonic Physician Partners | 1701 Golf Rd | 60008 |
| 9 | Advocate Lutheran General Physician Partners | 1701 Golf Rd | 60008 |
| 10 | Advocate MG Beverly | 9831 S Western Ave | 60646 |
| 11 | Advocate MG Burbank | 4901 W 79th St | 60459 |
| 12 | Advocate MG Evergreen | 1357 W 103rd St | 60643 |
| 13 | Advocate MG Halsted and Blackhawk | 1460 N Halsted St | 60642 |
| 14 | Advocate MG Irving and Western | 4025 N Western Ave | 60618 |
| 15 | Advocate MG Logan Square | 2511 N Kedzie Ave | 60647 |
| 16 | Advocate MG North Ave Oak Park | 6434 North Ave | 60639 |
| 17 | Advocate MG Orland Square | 29 Orland Square Dr | 60462 |
| 18 | Advocate MG Palos | 7620 W 111th St | 60645 |
| 19 | Advocate MG Six Corners/Ravenswood | 1945 W Wilson Ave | 60640 |
| 20 | Advocate MG South Holland | 80 River Oaks Dr | 60409 |
| 21 | Advocate MG Southeast | 2301 E 93rd St | 60617 |
| 22 | Advocate MG Sykes | 2545 S Dr Martin Luther King Dr | 60616 |
| 23 | Advocate Sherman Physician Partners | 1701 W Golf Rd | 60008 |
| 24 | Advocate South Suburban Physician Partners | 1701 Golf Rd | 60008 |
| 25 | Advocate Trinity Physician Partners | 1701 Golf Rd | 60008 |
| 26 | Affiliated Physicians Group LLC | 18410 S Crossing Dr | 60487 |
| 27 | Alexian Bros Clinically Integrated Network | 630 E Jefferson St | 61107 |
| 28 | Alternative Medicine Integration of Illinois, LLC | 5215 Old Orchard Rd | 60077 |
| 29 | Ambay Health Network | 4527 N Pulaski Rd | 60630 |
| 30 | Cadence Medical Partners - CentralDuPage Hospital | 2001 Gary Ave | 60187 |
| 31 | Cadence Medical Partners, LLC - Delnor | 2001 Gary Ave | 60187 |
| 32 | Calumet Physicians Associates LTD | 67 W 111th St | 60628-0000 |
| 33 | Centegra Health and Wellness Network | 4209 W Shamrock Ln | 60050 |
| 34 | Century P H O | 1029 N Sacramento Ave | 60622 |
| 35 | DMG Health Partners | 1100 W 31st St | 60515 |
| 36 | Dolton Medical Associates | 1851 S. Sibley Blvd | 60409 |
| 37 | Dreyer Medical Clinic Advocate | 1870 W Galena Blvd | 60506 |
| 38 | Edward Health Partners | 1100 W 31st St | 60515 |
| 39 | Elmhurst Health Partners | 1100 W 31st St | 60515 |
| 40 | Fox Valley Medicine LTD | 37W002 Mooseheart Rd | 60539 |
| 41 | Franciscan Hammond Clinic LLC | 7905 Calumet Ave | 46321 |
| 42 | Gottlieb PHO | 675 W North Ave | 60160-1634 |
| 43 | Health Options Of Illinois IPA | 4415 W Harrison St | 60162 |
| 44 | Health Plus Physicians Organization | 475 N Martingale Rd | 60173 |
| 45 | HealthSelect IPA | 18410 S Crossing Dr | 60477 |
| 46 | Hinsdale Physicians Health Care Association INC | 4415 W Harrison St | 60162 |
| 47 | HSHS Medical Group Inc | 4936 LaVerna Rd | 62707-9797 |
| 48 | Independent Physicians At Mercy | 2525 S Michigan Ave | 60616 |
| 49 | Ingalls Provider Group | One Ingalls Dr | 60426 |
| 50 | Innovative Physicians Associates | 4415 W Harrison | 60126 |
| 51 | Kane County IPA | 143 Lincoln Ave | 60505 |
| 52 | Lake County Physicians Association | 2615 Washington St | 60085 |
| 53 | Lawndale Christian Health Center | 3860 W Ogden Ave | 60623-2460 |
| 54 | Little Company of Mary Health Providers | 18410 S Crossing Dr | 60487 |
| 55 | Loyola University Physician Foundation | 2160 S First Ave | 60153 |
| 56 | MacNeal Health Providers | 750 Pasquinelli Dr | 60559 |
| 57 | Managed Health Care Associates, Ltd. | 2740 W Foster Ave | 60625-3532 |
| 58 | Medical Care Group | 701 Lee St | 60016 |
| 59 | Mercy Physician Association | 3430 Palmer Dr | 53547 |
| 60 | Methodist First Choice | 120 NE Glen Oak Ave | 61603 |
| 61 | NorthShore MG IPA | c/o Valence Health 600 W Jackson Blvd | 60661 |
| 62 | NorthShore Physician Associates | c/o Valence Health 600 W Jackson Blvd | 60661 |
| 63 | Northwest Community Health Partners | 675 W Central Rd STE 200 | 60005-0000 |
| 64 | Northwest Primary Care Alliance | 1786 Moon Lake Blvd | 60194 |
| 65 | Northwestern Health Care Corp NHC | 630 E Jefferson St | 61107-4026 |
| 66 | Northwestern Medical Faculty Foundation | 630 E Jefferson St | 61107-4026 |
| 67 | O S F Healthcare North | 9951 Rock Cut Crossing | 61111 |
| 68 | Oak West Primary Physicians Association | 4415 W Harrison St | 60162 |
| 69 | OSF Healthcare Central | 800 NE Glen Oak | 61603 |
| 70 | P E F Clinic LTD | 2850 S Wabash Ave | 60616 |
| 71 | Partners In Health, Inc. | 326 W 64th St | 60621 |
| 72 | Physicians Care Network, INC. | 630 E Jefferson St | 61107 |
| 73 | Physicians Health Association Of Illinois | 630 E Jefferson St | 61107 |
| 74 | Presence Resurrection | 7435 W Talcott | 60631 |
| 75 | Presence St Francis | 2380 E Dempster St | 60016 |
| 76 | PRESENCE ST JOSEPH H P JOLIET | 2380 E Dempster Street | 60016 |
| 77 | Presence St Josephs | 2380 E Dempster St | 60016 |
| 78 | Presence St Mary & Elizabeth | 2380 E Dempster St | 60016 |
| 79 | Primary Care Joliet | 2025 S Chicago St | 60436 |
| 80 | Progress Health | 2701 W 68th St | 60629 |
| 81 | Pronger Smith MedicalCare | 17495 La Grange Rd | 60487 |
| 82 | Ravenswood Physicians Associates | 4100 N Lincoln Ave | 60618 |
| 83 | Resurrection Phys Provider Group | 5860 W Higgins Ave | 60630 |
| 84 | Silver Cross Managed Care Organization | 1200 W Maple Rd | 60432 |
| 85 | Sinai Medical Group | 3109 W Armitage Ave | 60647 |
| 86 | Southern Illinois Health Care Association | 531 Vandalia St | 62234 |
| 87 | Southland IPA | 8501 W 191st Street | 60448 |
| 88 | Southwest Physicians Group LTD | 4861 W 95th St | 60453 |
| 89 | St Anthony Health Network | 7905 S Calumet Ave | 4646321307 |
| 90 | St. Francis Health Care LTD | 6677 N Lincoln Ave | 60712-3634 |
| 91 | St. James PHO INC | 30 E 15th St | 60411 |
| 92 | Thorek Family Health Network | 5215 Old Orchard Rd | 60077 |
| 93 | U I C Physician Group | 820 S Wood St STE W310 | 60612 |
| 94 | Unified Physicians Network | 5215 Old Orchard Rd | 60077 |
| 95 | Weiss Healthcare System PHO | 4100 N Lincoln Ave | 60618 |
| 96 | Weiss Physician Group | 750 Pasquinelli Dr | 60559 |
| 97 | West Suburban Health Providers | PO Box 9237 | 60522-9237 |
| end |  |  |  |

EXHIBIT XII

RESERVED

EXHIBIT XIII – A

**CITY OF CHICAGO**

**CLAIMS DATA**

**CONFIDENTIAL CD**

<< attached by reference >>

EXHIBIT XIII – B

**CHICAGO PARK DISTRICT**

**CLAIMS DATA**

**CONFIDENTIAL CD**

<< attached by reference >>

EXHIBIT XIII – C

**CHICAGO PUBLIC SCHOOLS**

**CLAIMS DATA**

**CONFIDENTIAL CD**

<< attached by reference >>

EXHIBIT XIV

**CITY OF CHICAGO**

**DATA PROTECTION REQUIREMENTS FOR CONTRACTORS, VENDORS, AND THIRD PARTIES**

“Breach” means the acquisition, access, use, or disclosure of Protected Information that compromises the security or privacy of the Protected Information.

"Contractor" means an entity that receives or encounters Protected Information. Contractor includes, without limitation, entities that store Protected Information, or host applications that process Protected Information. The provisions of this Data Policy includes not only the entity that is a signatory to this Policy but all subcontractors, of whatever tier, of that entity; the signatory must inform and obtain the agreement of such subcontractors to the terms of this Data Policy.

“Protected Information” means all data provided by City to Contractor or encountered by Contractor in the performance of the services to the City, including, without limitation, all data sent to Contractor by City and/or stored by Contractor on its servers. Protected Information includes, but is not limited to, employment records, medical and health records, personal financial records (or other personally identifiable information), research data, and classified government information. To the extent there is any uncertainty as to whether any data constitutes Protected Information, the data in question shall be treated as Protected Information.

1. Information Security. Contractor agrees to the following:  
   1. General. Notwithstanding any other obligation of Contractor under this policy, Contractor agrees that it will not lose, alter, or delete, either intentionally or unintentionally, any Protected Information, and that it is responsible for the safe-keeping of all such information, except to the extent that the City directs the Contractor in writing to do so.
   2. Access to Data. In addition to the records to be stored / maintained by Contractor, all records that are possessed by Contractor in its service to the City of Chicago to perform a governmental function are public records of the City of Chicago pursuant to the Illinois Freedom of Information Act (FOIA), unless the records are exempt under the Act. FOIA requires that the City produce records in a very short period of time. If the Contractor receives a request from the City to produce records, the Contractor shall do so within 72 hours of the notice.
   3. Minimum Standard for Data at Rest and Data in Motion. Contractor must, at a minimum, comply, in its treatment of Protected Information, with National Institute of Standards and Technology (NIST) Special Publication 800-53 Moderate Level Control. Notwithstanding this requirement, Contractor acknowledges that it must fully comply with each additional obligation contained in this policy. If data is protected health information or electronic protected health information, as defined in the Health Insurance Portability and Accountability Act and Health Information Technology for Economic and Clinical Health Act (HIPAA/HITECH) and regulations implementing these Acts (see 45 CFR Parts 160 and 164), it must be secured in accordance with “Guidance Specifying the Technologies and Methodologies that Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals,” available on the United States Department of Health and Human Services (HHS) website *http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/index.html*, or at Volume 74 of the Federal Register, beginning at page 42742. That guidance from the HHS states that valid encryption processes for protected health information data at rest (e.g., protected health information resting on a server), must be consistent with the NIST Special Publication 800-111, Guide for Storage Encryption Technologies for End User Devices. Valid encryption processes for protected health information data in motion (e.g., transmitted through a network) are those which comply with NIST Special Publications 800-52, Guidelines for the Selection and Use of Transport Layer Security Implementation; 800-77, Guide to IPsec VPNs; or 800-113, Guide to SSL VPNs, or others which are Federal Information Processing Standards (FIPS) 140-2 validated.
   4. Where Data is to be Stored. All data must be stored only on computer systems located in the continental United States.
   5. Requirement to Maintain Security Program. Contractor acknowledges that the City has implemented an information security program to protect the City’s information assets, which Program is available on the City website at *http://www.cityofchicago.org/city/en/depts/doit/supp\_info/is-and-it-policies.html* (“City Program”). Contractor shall be responsible for establishing and maintaining an information security program that is designed to: (i) ensure the security and confidentiality of Protected Information; (ii) protect against any anticipated threats or hazards to the security or integrity of Protected Information; (iii) protect against unauthorized access to or use of Protected Information; (iv) ensure the proper disposal of Protected Information; and, (v) ensure that all subcontractors of Contractor, if any, comply with all of the foregoing.
   6. Undertaking by Contractor. Without limiting Contractor’s obligation of confidentiality as further described herein, in no case shall the safeguards of Contractor’s information security program be less stringent than the information security safeguards used by the City Program.
   7. Right of Audit by the City of Chicago. The City of Chicago shall have the right to review Contractor’s information security program prior to the commencement of Services and from time to time during the term of this Agreement. During the performance of the Services, from time to time and without notice, the City of Chicago, at its own expense, shall be entitled to perform, or to have performed, an on-site audit of Contractor’s information security program. In lieu of an on-site audit, upon request by the City of Chicago, Contractor agrees to complete, within forty-five (45 days) of receipt, an audit questionnaire provided by the City of Chicago or the City of Chicago’s designee regarding Contractor’s information security program.
   8. Audit by Contractor. No less than annually, Contractor shall conduct an independent third-party audit of its information security program and provide such audit findings to the City of Chicago, all at the Contractor’s sole expense.
   9. Audit Findings. Contractor shall implement at its sole expense any remedial actions as identified by the City as a result of the audit.
   10. Demonstrate Compliance - PCI. No less than annually, as defined by the City of Chicago and where applicable, the Contractor agrees to demonstrate compliance with PCI DSS (Payment Card Industry Data Security Standard). Upon City’s request, Contractor must be prepared to demonstrate compliance of any system or component used to process, store, or transmit cardholder data that is operated by the Contractor as part of its service. Similarly, upon City’s request, Contractor must demonstrate the compliance of any third party it has sub-contracted as part of the service offering. As evidence of compliance, the Contractor shall provide upon request a current attestation of compliance signed by a PCI QSA (Qualified Security Assessor).
   11. Demonstrate Compliance – HIPAA / HITECH. If the Protected Information includes protected health information or electronic protected health information covered under HIPAA/HITECH, Contractor must execute, and be governed by, the provisions in its contract with the City regarding HIPAA/HITECH, the regulations implementing those Acts, and the Business Associate Agreement in its contract with the City. As specified in 1.3, protected health information must be secured in accordance with the “Guidance Specifying the Technologies and Methodologies that Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals.”
   12. Data Confidentiality. Contractor shall implement appropriate measures designed to ensure the confidentiality and security of Protected Information, protect against any anticipated hazards or threats to the integrity or security of such information, protect against unauthorized access or disclosure of information, and prevent any other action that could result in substantial harm to the City of Chicago or an individual identified with the data or information in Contractor’s custody.
   13. Compliance with All Laws and Regulations. Contractor agrees that it will comply with all laws and regulations.
   14. Limitation of Access. Contractor will not knowingly permit any Contractor personnel to have access to any City of Chicago facility or any records or data of the City of Chicago if the person has been convicted of a crime in connection with (i) a dishonest act, breach of trust, or money laundering, or (ii) a felony. Contractor must, to the extent permitted by law, conduct a check of public records in all of the employee’s states of residence and employment for at least the last five years in order to verity the above. Contractor shall assure that all contracts with subcontractors impose these obligations on the subcontractors and shall monitor the subcontractors’ compliance with such obligations.
   15. Data Re-Use. Contractor agrees that any and all data exchanged shall be used expressly and solely for the purposes enumerated in the Agreement. Data shall not be distributed, repurposed or shared across other applications, environments, or business units of Contractor. As required by Federal law, Contractor further agrees that no City of Chicago data of any kind shall be revealed, transmitted, exchanged or otherwise passed to other Contractors or interested parties except on a case-by-case basis as specifically agreed to in writing by an officer of the City of Chicago with designated data, security, or signature authority.
   16. Safekeeping and Security. Contractor will be responsible for safekeeping all keys, access codes, passwords, combinations, access cards, personal identification numbers and similar security codes and identifiers issued to Contractor’s employees, agents or subcontractors. Contractor agrees to require its employees to promptly report a lost or stolen access device or information to their primary business contact and to the City of Chicago Information Security Office.
   17. Mandatory Disclosure of Protected Information. If Contractor is compelled by law or regulation to disclose any Protected Information, the Contractor will provide to the City of Chicago with prompt written notice so that the City of Chicago may seek an appropriate protective order or other remedy. If a remedy acceptable to the City of Chicago is not obtained by the date that the Contractor must comply with the request, the Contractor will furnish only that portion of the Protected Information that it is legally required to furnish, and the Contractor shall require any recipient of the Protected Information to exercise commercially reasonable efforts to keep the Protected Information confidential.
   18. Data Breach. Contractor agrees to comply with all laws and regulations relating to data breach, including without limitation, the Illinois Personal Information Protection Act and other applicable Illinois breach disclosure laws and regulations. Data breaches of protected health information and electronic protected health information shall be governed by the provisions regarding HIPAA/HITECH, and the regulations implementing those Acts, in the Contractor’s contract with the City, specifically the Business Associate Agreement in such contract. Contractor will immediately notify the City if security of any Protected Information has been breached, and will provide information as to that breach in such detail as requested by the City. Contractor will, if requested by the City, notify any affected individuals of such breach at the sole cost of the Contractor.
   19. Data Sanitization and Safe Disposal. All physical and electronic records must be retained per federal, state and local laws and regulations, including the Local Records Act. Where disposal is approved, the Contractor agrees that prior to disposal or reuse of all magnetic media (e.g. hard disk, floppy disk, removable media, etc.) which may have contained City of Chicago data shall be submitted to a data sanitization process which meets or exceeds DoD 5220.28-M 3-pass specifications. Certification of the completion of data sanitization shall be provided to the City of Chicago within 10 days of completion. Acceptance of Certification of Data Sanitization by the Information Security Office of the City of Chicago is required prior to media reuse or disposal. All other materials which contain City of Chicago data shall be physically destroyed and shredded in accordance to NIST Special Publication 800-88, Guidelines for Media Sanitization, specifications.
   20. End of Agreement Data Handling. The Contractor agrees that upon termination of this Agreement it shall return all data to the City of Chicago in a useable electronic form, and erase, destroy, and render unreadable all data in its entirety in accordance to the prior stated Data Sanitization and Safe Disposal provisions. Data must be rendered in a manner that prevents its physical reconstruction through the use of commonly available file restoration utilities. Certification in writing that these actions have been completed must be provided within 30 days of the termination of this Agreement or within 7 days of a request of an agent of the City of Chicago, whichever shall come first.

◘

EXHIBIT XV

**DEFINITIONS and ACRONYMS**

For purposes of this RFP, the following definitions shall apply, unless as may otherwise be used.

**ABA –** Applied Behavioral Analysis

**Agency –** any one of the following governmental entities: City of Chicago; Chicago Park District; or the Chicago Board of Education Chicago Public Schools.

**Agreement** – means the contract executed between the Agency and Respondent parties, pursuant to this Request for Proposal process.

**Capitation** – a method of payment for health services in which an individual or institutional provider is paid a fixed, per capita amount for each person served, without regard to the actual number or nature of services provided to each person.

**Census of Covered Persons** – means an electronic file containing demographic information about Covered Persons.

**Certificates of Coverage** – indicates the current terms of coverage and benefits available in an Agency’s Benefit Plans.

**Claim** – notification to the Contractor from either a Provider or from a Covered Person, that HMO Covered Services have been furnished to a Covered Person, accompanied by a demand for payment or reimbursement for such benefits.

**COB –** Coordination of Benefits

**Collective Bargaining Agreement** – means an agreement between the Agency or Agencies and a labor organization that represents certain employees of the Agency. The Agency may be a party to one or more Collective Bargaining Agreements.

**Contractor** – means the Respondent awarded a contract pursuant to this Request for Proposal process.

**Coordination of Benefits** – a process for determining the respective responsibilities of two or more healthcare plans that have some portion of responsibility for a medical claim.

**Co-Payment or “Co-Insurance** – means that a portion of the charge for each covered service provided to the Covered Person is the responsibility of the Covered Person as determined in accordance with the Agency’s Benefit Plan. Co-Payment or Co-Insurance may be in the form of a specified dollar amount, a fixed amount, or a percentage of charges, with the balance, if any, paid by the Plan.

**Covered Person** – means the individual who has been reported to Contractor by the Agency as eligible to receive HMO benefits in accordance with the terms of the Agency’s Benefit Plan.

**Desk Audit** – means an independent evaluation of procedures to determine compliance, including objective assurance that the Services are being delivered in accordance with the terms of the Agreement.

**Drug Utilization –** the ability to monitor and assess the appropriateness, safety, and efficacy of drug therapy and usage.

**Electronic Claim** – a digital representation of a claim generated by the Participating Providers.

**EOP** – Explanation of Benefits

**Geo - Access or Geo Zip Report -** means a report prepared by Contractor which illustrates what percentage of Covered Persons have access to a Participating Provider and to 24-hour Participating Providers based upon an analysis of the zip code of residence of the Covered Persons and the zip code location of all participating Providers in the national network. For purposes of the report, a Covered Person is considered to have adequate access if there is a Provider within 5 miles of the zip code of residence of the Covered Person.

**IBNR** – Incurred but not reported.

**Identification Card** – means Contractor’s standard single purpose (NCPDP format) printed identification card containing information about the Covered Person sufficient to permit a Provider to submit a Claim for a Covered Service for the Covered Person to Contractor for adjudication.

**Implementation Materials** – means those printed materials that are sent to each Covered Person who is eligible to receive Services. The materials will be of sufficient quality and quantity so that the Covered Person will be informed about Contractor, and will know how to obtain Services in accordance with the Agency’s Benefit Plan.

**MAC** – Maximum Allowable Cost.

**MH** – Mental Health.

**New Enrollee Materials** – means those printed materials that are sent to each Subscriber who becomes eligible to receive Covered Services. The materials will be of sufficient quality and quantity so that the Subscriber and all Covered Persons will be informed about Contractor, and will know how to obtain Covered Services in accordance with the Agency’ Benefit Plan.

**Open Enrollment Period** –that period of time, generally once during a calendar year, designated by the Agencies, during which Plan enrollment is managed.

**Out-of-Pocket** – a Covered Person’s Deductible (if applicable); also co-payments or co-insurance payments made by a Covered Person.

**Paper Claims** - means a claim for a Covered Service submitted on paper by a Covered Person or by Medicare. Either the Covered Person or Medicare will have paid for the Covered Service in its entirety and is seeking reimbursement from Contractor in accordance with the Agency’s Benefit Plan.

**PCP** – Primary Care Physician.

**Patient Profile Data** – means the Covered Person’s history processed by Contractor or otherwise provided to Contractor. This history shall include information on the Covered Person’s general health condition, if available.

**PHO** – Physician Hospital Organization

**PHSA** – Public Health Service Act.

**Plan** – means the set of benefits provided under the Agreement.

**Plan Design Document or** **PDD** – the document prepared by Contractor and approved by the Agencies, which summarizes the Agencies’ plan designs for the agreed benefit Services to be administered to the Agencies by the Contractor.

**Plan Document** – the document that contains all of the provisions, conditions, and terms of operation of the Plan.

**Plan Sponsor –** an entity that sponsors a health plan, e.g., employer, a union, or some other entity.

**Providers** – any individual or entity, laboratory, or physician, furnishing medical, mental health, dental, or pharmacy services.

**R&C** – Reasonable and Customary

**Respondent –** means the entity that submits a proposal in response to this RFP. The documents submitted will be referred to as "**Proposals**."

**Services** – means the services required to be performed by the Contractor in accordance with the Agreement.

**Subscriber** – is an employee of an Agency whose employment is the basis for enrolling themselves (and their designated Covered Person or Persons) into membership with the Contractor’s HMO healthcare plan under the Agreement.

**Third Party Administrator**  – business associate that performs Claims administration and related business functions for a self-insured entity.

**U&C** – Usual and Customary

**Utilization Management Programs** – means programs developed by Contractor to insure utilization of Services in accordance with generally accepted medical practice standards and cost efficiency for both the Covered Person and the City.

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EXHIBIT XVI – A

**CITY OF CHICAGO**

**BUSINESS ASSOCIATE AGREEMENT**

The City of Chicago (“City”) and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“Business Associate”) agree to the following terms and conditions, which are intended to comply with the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and their implementing regulations:

The terms below that are capitalized and in bold have the same meanings as set forth in the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, which is part of the American Recovery and Reinvestment Act of 2009, and the regulations promulgated thereunder, including the privacy, security, breach, omnibus, and enforcement rules, as each may be amended from time to time (collectively, “HIPAA”). See 45 CFR parts 160 and 164.

Specifically, the following terms used in the Business Associate Agreement shall have the same meaning as in HIPAA: **Breach,** **Business Associate, Covered Entity, Data Aggregation, Designated Record Set, Disclosure, Financial Remuneration, Fundraising, Health Care Operations, Individual, Marketing, Minimum Necessary, Notice of Privacy Practices, Protected Health Information (“PHI”), Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information**, and **Use.** The term “**Breach**” has the meaning as set forth in HIPAA when capitalized below, but has the ordinary dictionary meaning when not capitalized below.

For purposes of this Business Associate Agreement, the term “Protected Health Information” or “PHI” includes electronic PHI, also known as ePHI.

1. Interpretation of this Business Associate Agreement. A reference in this Business Associate Agreement to HIPAA means the section in effect or as amended. If there is a dispute as to whether Business Associate is, in fact, a Business Associate, the Business Associate must provide a legal memorandum to the City indicating why the Business Associate does not fall under the definition of Business Associate in HIPAA. If the City disagrees with the legal memorandum regarding the Business Associate’s conclusion that Business Associate is not a Business Associate, the City may choose to report a Breach to the Secretary or take other measures as deemed necessary to ensure the City’s compliance with HIPAA. Any ambiguity or inconsistency in this Business Associate Agreement shall be resolved in favor of a meaning that permits City to comply with HIPAA.

2. Amendment of this Business Associate Agreement. The parties hereto agree to negotiate in good faith to amend this Agreement from time to time as is necessary for City to comply with the requirements of HIPAA and for Business Associate to provide services to City. However, no change, amendment, or modification of this Agreement shall be valid unless it is set forth in writing and signed by both parties.

3. Designation of HIPAA Officer(s). Business Associate agrees to designate, in writing, a HIPAA Privacy and Security Officer(s) who will communicate with the City’s HIPAA Privacy and Security Officers for purposes of this Agreement. Business Associate agrees to notify the City’s HIPAA Privacy and Security Officers of such designation and the contact information of such officer(s):

Jennifer Herd Paul Bivian

HIPAA Privacy Officer HIPAA Security Officer

312-747-9429 312-744-2250

hipaaprivacyofficer@cityofchicago.org hipaasecurityofficer@cityofchicago.org

4. Uses and Disclosures of PHI. Business Associate must not use or further disclose Protected Health Information (“PHI”) other than as permitted or required by this Agreement, as necessary to perform the services in this Agreement, or as required by law.

a. Business Associate will not sell PHI or use or disclose PHI for the purposes of marketing or

fundraising.

b. Business Associate shall not directly or indirectly receive financial remuneration in exchange for

any PHI of an individual or in exchange for making communications regarding treatment or health care operations purposes, unless otherwise allowed in this Agreement.

c. If Business Associate is authorized to use PHI to provide the City with de-identified information, Business Associate is not permitted to use or disclose the de-identified information for purposes other than those specified in the Agreement.

d. Business Associate may use PHI to provide data aggregation services to the City, relating to the health care operations of the City.

e. Business Associate may use and disclose PHI received by the Business Associate in its capacity as a Business Associate to the City, if necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that, as to any such disclosure, the following requirements are met:

i. The disclosure is required by law; or

ii. The Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially 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 Business Associate of any instances of which it is aware in which the confidentiality of the information has been the subject of a Breach.

f. Except as otherwise limited in this Agreement, Business Associate may use and disclose PHI obtained from or on behalf of the City to perform functions, activities, or services for, or on behalf of, the City as specified in the Agreement, provided that such use or disclosure would not violate HIPAA if done by the City.

5. Minimum Necessary. Business Associate shall use, disclose, or request only the minimum necessary PHI necessary to accomplish the intended purpose of the use, disclosure, or request. Business Associate represents that the PHI used, disclosed, or requested by Business Associate is the minimum necessary to carry out purposes of the Agreement. Prior to any use or disclosure, Business Associate shall determine whether a limited data set would be sufficient for these purposes.

6. Safeguards of PHI. Business Associate must use appropriate safeguards with respect to PHI that it creates, receives, maintains, or transmits on behalf of the City to prevent the use or disclosure of PHI other than as provided for in this Agreement. The safeguards must reasonably protect PHI from any intentional or unintentional use or disclosure in violation of HIPAA privacy regulations (45 CFR Part 164, subpart E) and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Agreement. The safeguards must also reasonably and appropriately protect the confidentiality, integrity, and availability of PHI that Business Associate creates, receives, maintains, or transmits on the City’s behalf as required by the HIPAA security regulations (45 CFR Part 164, subpart C). Where applicable, Business Associate must comply with the HIPAA security regulations (45 CFR Part 164, subpart C) with respect to electronic protected health information, to prevent the use or disclosure other than as provided for by this Agreement. Where feasible, PHI will not leave the City’s facilities and will be accessed under the supervision of City employees.

7. Applicability of Business Associate Agreement to Subcontractors and Agents. Business Associate must ensure that any agent, including a subcontractor, that creates, receives, maintains, or transmits PHI on behalf of the Business Associate agrees to the same restrictions, conditions, and requirements that apply through this Agreement to Business Associate with respect to such information, by entering into a contract or other arrangement that complies with HIPAA. An agent or subcontractor of a Business Associate is not permitted to use or disclose PHI in a manner that would not be permissible if done by the Business Associate. Business Associate will ensure that its subcontractors and agents to which Business Associate is permitted by this Agreement or in writing by the City to disclose PHI agree to implement reasonable and appropriate safeguards to protect PHI. Business Associate will obtain reasonable assurances from any subcontractors and agents to which Business Associate discloses PHI that the subcontractor or agent will hold PHI in confidence and further use or disclose PHI only for the purpose for which Business Associate disclosed PHI to the subcontractor or agent or as required by law.

Business Associate will obtain reasonable assurances that any subcontractor or agent to which Business Associate discloses PHI will notify the Business Associate within 5 calendar days (who will, in turn, notify the City within 5 calendar days, as described below) of any instance in which the subcontractor or agent becomes aware of a Breach of unsecured PHI; possible Breach of unsecured PHI; any security incident of which it becomes aware, including: any attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI; or any attempted or successful interference with agent or subcontractor’s system operations of which agent/subcontractor becomes aware.

Agent/subcontractor is not required to report the following types of unsuccessful security incidents: pings and other broadcast attacks on agent/subcontractor’s firewall, port scans, unsuccessful log-on attempts, denial of service attacks, and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of PHI.

If a delay is requested by a law enforcement official in accordance with 45 CFR 164.412, agent/subcontractor may delay notification to Business Associate for the time period specified in HIPAA. Agent or subcontractor’s report will include the information described in 45 CFR 164.404(c) and such other information as the Business Associate or the City may reasonably request.

8. Reporting of Breaches, Potential Breaches, and Security Incidents. Business Associate must report to the City any use or disclosure of the PHI not provided for by this Agreement of which it becomes aware, as well as any Breach of Unsecured PHI; potential Breach of unsecured PHI; any security incident of which it becomes aware; any attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI; or any attempted or successful interference with Business Associate’s system operations of which Business Associate becomes aware.

Business Associate will make the report to the City’s HIPAA Privacy and Security Officers not more than five (5) calendar days after Business Associate discovers such non-permitted use or disclosure, Breach, security incident, or other incident as described above. Business Associate shall provide any reports or notices required by HIPAA as a result of Business Associate’s Breach. On behalf of the City, Business Associate will provide such reports or notices to any party or entity (including but not limited to media, Secretary, and individuals affected by the Breach) entitled by law to receive the reports or notices. Business Associate agrees to pay the costs associated with notifying individuals affected by the Breach, which may include, but are not limited to, paper, printing, and mailing costs.

Business Associate is not required to report the following types of unsuccessful security incidents: pings and other broadcast attacks on Business Associate’s firewall, port scans, unsuccessful log-on attempts, denial of service attacks, and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of PHI.

If a delay is requested by a law enforcement official in accordance with 45 CFR 164.412, Business Associate may delay notifying City for the time period specified in HIPAA. Business Associate’s report will include the information described in 45 CFR 164.404(c) and such other information as the City may reasonably request.

9. Mitigation and Penalties. Business Associate must mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Breach or of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement. Business Associate shall take reasonable steps to put corrective measures in place to prevent future Breaches (such as retraining employees and upgrading security systems). At the City’s request, Business Associate shall take reasonable steps to mitigate the harm to affected Individuals whose PHI has been or may have been compromised as a result of a Breach by Business Associate, including obtaining credit monitoring services and offering identity theft insurance. To the extent that the City incurs civil or criminal monetary penalties as a result of a Breach by the Business Associate, the Business Associate agrees to reimburse the City for such penalties.

10. Designated Record Sets - Access. If the Business Associate has PHI in a Designated Record Set, then Business Associate must provide access to or otherwise make available, at the request of the City, and in the time and manner designated by the City, PHI in a Designated Record Set, to the City or, as directed by City, to an Individual in order to meet the requirements under 45 CFR 164.524.

11. Designated Record Sets – Amendments. If the Business Associate has PHI in a Designated Record Set, then Business Associate must make any amendments to PHI in a Designated Record Set that the City directs or agrees to pursuant to 45 CFR 164.526 at the request of City or an Individual, and in the time and manner designated by the City.

12. Internal Practices, Books, and Records. Business Associate must make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, the City available to the Secretary for purposes of determining compliance with HIPAA. Business Associate also must make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, the City available to the City in a time and manner designated by the City, for purposes of the Secretary determining City’s compliance with HIPAA.

13. Accounting of Disclosures - Documentation. Business Associate must document the disclosures of PHI and information relating to such disclosures as would be required for City to respond to a request by an individual for an accounting of disclosures of PHI in accordance with HIPAA, specifically 45 CFR 164.528.

14. Accounting of Disclosures – Provision of Information. Business Associate must provide to City or an individual, in time and manner designated by City, information collected which relates to the disclosure of PHI, to permit City to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. If the Business Associate receives a request for accounting of disclosures directly from the individual, the Business Associate must respond to such request for an accounting of disclosures, provide the accounting of disclosures to the individual within the time required by 45 CFR 164.528, and provide the information regarding such request to the City, in the time and manner designated by the City.

15. Survival, Termination, and Return or Destruction of PHI. Upon termination of this Agreement for any reason, the Business Associate’s obligations under these contractual obligations shall survive termination and remain in effect:

(a) until Business Associate has completed the return or destruction (in accordance with the US Department of Health and Human Services’ Guidance to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals) of all of the PHI provided by City to Business Associate, or created or received by Business Associate on behalf of City, and

(b) to the extent that Business Associate retains any PHI.

Upon the expiration or termination of the underlying Agreement, if feasible, the Business Associate must either:

(1) return all PHI received from the City, or created, maintained, or received by Business Associate on behalf of the City, which the Business Associate still maintains in any form, to the City or

(2) destroy it, at the City’s option (in accordance with the US Department of Health and Human Services’ Guidance to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals).

This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

If Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. If it is infeasible for Business Associate to obtain, from a subcontractor or agent any PHI in the possession of the subcontractor or agent, Business Associate shall require the subcontractors and agents to agree to extend any and all protections, limitations and restrictions contained in this Agreement to the subcontractors’ and/or agents’ use and/or disclosure of any PHI retained after the termination of this Agreement, and to limit any further uses and/or disclosures to the purposes that make the return or destruction of the PHI infeasible.

In the event of a breach of the terms of these contractual obligations, the cure and remedies of the Agreement shall govern. HIPAA’s privacy rule (45 CFR § 164.504(e)(2)) requires that the Business Associate will authorize termination of the contract by the City, if the City determines that the Business Associate has violated a material term of these contractual obligations.

16. Compliance with Obligations. To the extent the Business Associate is to carry out one or more of City’s obligation(s) under Subpart E of 45 CFR Part 164, the Business Associate must comply with the requirements of Subpart E that apply to the City in the performance of such obligation(s). Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the City.

17. No Third Party Rights. The terms and conditions of this Agreement are intended for the sole benefit of Business Associate and City and do not create any third party rights.

18. Governing Law. To the extent not preempted by federal law, the Agreement shall be governed and construed in accordance with the laws of the State of Illinois.

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EXHIBIT XVI – B

**CHICAGO PARK DISTRICT**

**BUSINESS ASSOCIATE AGREEMENT**

<< attached by reference >>

EXHIBIT XVI – C

**CHICAGO PUBLIC SCHOOLS**

**BUSINESS ASSOCIATE AGREEMENT**

<< attached by reference >>

EXHIBIT XVII

**AGENCIES’ INTERROGATIVES**

**HMO – General**

1. Provide the full legal name and corporate headquarters address of your company as the Respondent entity. List the address(es) of your Chicago metropolitan area offices and/or the address of the location where the Agencies’ accounts will be managed. Provide an organizational chart of the administrative and medical management of the HMO, and include a description of the expected staffing levels, titles, and resources the HMO expects to commit in order to perform the required services.

2. What year was your company established? Provide the history and present ownership of your company, including the names, if any, of your company’s subsidiaries and other entities that you own or that you are owned by. Document that your organization is licensed to do business in Illinois, and that your organization is in compliance with both the requirements of the insurance laws and the requirements of the duly constituted insurance regulatory authority of the State of Illinois and any other state in which your company operates. Provide a copy of your Certificate of Authority.

3. Describe the organization and capitalization of your company. For any privately held organization, list all principal owners and shareholders. For publicly traded companies, list any shareholder with an interest greater than 5%. Provide the percentage of ownership interest held by another organization, if any, including their relationship to your company as the Respondent.

4. Has your company’s license to do business in the State of Illinois been revoked, cancelled, or suspended in the last five (5) years? If yes, explain.

5. Has any part of your company or any of its officers, directors, or owners filed for bankruptcy or reorganization within the last three (3) years? If yes, provide all pertinent details of these actions.

6. Do you now have or have you ever had a contract with the any of the Agencies, to provide any product or services? If so, list each such contract with date of inception, termination, or expiration including a brief description of the services provided.

7. Is your company or any subcontractor or any subsidiary within your company’s organization currently engaged in or have any pending service contracts, which may result in a conflict of interest with the any of the Agencies? If yes, describe the potential or actual conflict of interest.

8. List all subcontractors that your company, as Respondent, would expect to engage to either directly provide or indirectly assist in the provision of services under a contract with the Agencies; include firm names, addresses, contact persons, and a detailed description of the Services to be subcontracted. Include descriptive information concerning subcontractor’s organization, abilities and commitment to the contract period.

9. Is your organization or any of its subsidiaries or affiliates currently the subject of any lawsuits or investigations relating to your business practices? Is your organization involved in any litigation that could affect its ability to meet the RFP’s requirements?

10. Describe recent (within the last 24 months) and planned/pending changes in your organization, such as mergers, stock issues, acquisitions, spin-offs, etc. Include agreements, letters of intent, comparable documents, or official notices or announcements pertaining to such agreements which verify the company’s structure.

11. Provide both your and any affiliated entities’ three most recent annual financial stability ratings (e.g., Best’s, Moody’s and Standard & Poor’s).

\*Provide your current financial ratings and date when the rating was received

|  |  |  |
| --- | --- | --- |
|  | Rating | Date (if rated; if not rated indicate Not Rated) |
| A.M. Best: Rating Status |  |  |
| Financial Rating (if rated) |  |  |
| Standard & Poor’s: Rating Status |  |  |
| Financial Rating (if rated) |  |  |
| Fitch: Rating Status |  |  |
| Financial Rating (if rated) |  |  |
| Moody’s: Rating Status |  |  |
| Financial Rating (if rated) |  |  |
| Respondent’s rating change within the past 12 months (No Change, Not Rated, Improved, Decreased): |  |  |

12. Will your organization represent and warrant that it is qualified to: (i) develop, (ii) maintain, and (iii) administer an HMO Health Maintenance Organization network (as specified in the Scope of Services) and (iv) that you have exercised all due diligence and professional judgment in the selection and retention of Participating Providers? Further, (v) do you agree that you understand that the Agencies will rely upon these representations and warranties in its selection process and during the term of any Agreement? Please specifically respond to each of these questions. If you do not answer in the affirmative, specify the reasons why you are not able to respond in the affirmative.

13. How many other clients does the proposed primary account manager, proposed to service the Agencies, currently have, and what are the sizes of these client accounts?

14. Provide a detailed timetable (Gantt Chart) geared toward a January 1, 2016 implementation date, indicating the earliest completion dates your organization would be able to implement all significant tasks. This timetable must be of sufficient detail to serve as an actual work plan and must include, but not be limited to:

1. Initial planning meeting;
2. Coordination with the benefit management staffs of the Agencies;
3. Communications development and production;
4. Customer Service Training
5. Network development;
6. Development of systems capabilities;
7. Agreement development and execution among Agencies
8. Network development
9. Assignment of unique ID numbers
10. Transition of care planning; approval of continuing care plans

15. Regarding Services involving unionized employee groups, describe your experience with collective bargaining units of over forty thousand (40,000) employees.

16. Provide the names, email addresses, telephone numbers, and a brief biography of all key personnel that will be committed to provide Services; include his/her résumé and experience with public sector employees. Also provide the contact information of the individuals (exclude marketing representatives and account executives) within your organization who are able to answer technical and professional questions related to your proposal.

17. Describe in detail how your organization would implement the addition of more than 80,000 Subscribers to your client base. If you are selected, and you are not a current service provider, explain how you will transition this group from the existing carrier to your organization to insure continuity of medical service required under the existing plan designs. Be specific as to what data you would require from the current carrier(s) in order to assure a smooth transition. Provide a copy of your Transition if Care protocol and a sample explanation that could be provided to members that are receiving or would receive complex medical services during the transition to a new HMO provider.

18. For the identification cards which you would provide the Agencies’ Subscribers, what constitutes the employee member number (e.g., social security number, payroll number, other)? Describe the creation and mailing process, including timeframes, to accomplish distribution. Are you willing to use employer provided UID numbers?

19. At its option, an Agency may request that your logo be placed on the face of their medical I.D. cards. Confirm your agreement with this request. (Several Agencies have carved-out PBM services and would intend to continue to do so.)

20. Is there a process for Subscribers to submit paper claims for out of area services? Are there additional costs for this?

21. What are your general business hours and days? What are your hours and days for member customer service? Do you have a toll free number? Would there be a separate toll free number for each of the Agencies? Are physician groups required to have a 24 hour/7 day emergency number available for members? What are the requirements for this physician group’s service? Are physician groups required to have a contract with urgent care or other retail clinics for provision of emergent/urgent services outside of normal business hours?

22. When a Plan member calls the toll free number, what are the qualifications of the person who answers the call? Is there an automated attendant? If so, how many choices is the caller offered (e.g., potential buttons to press)? Is there a live person available during your hours of operation? Do you have a website for enrollee inquiries? How do you insure privacy?

23. Include the following attachments, per Table 1 below, as part of your proposal response. Please confirm they are included.

Table 1 - Respondent Attachments

|  |  |  |  |
| --- | --- | --- | --- |
| **Attachments** | **Description** | **Included (yes/no)** | |
| A | Provide Sample Standard Reports available |  |  |
| B | Sample Subrogation/Accident Request for Information Letter |  |  |
| C | Sample ID Cards |  |  |
| D | Sample Case Management Reports |  |  |
| E | Sample Explanation of Benefits |  |  |
| F | Sample Preauthorization Denial Letter |  |  |
| G | Sample First-Level Appeal Denial Letter (grandfathered and non-grandfathered) |  |  |
| H | Sample Claims Processing Agreement |  |  |
| I | Sample Business Associate Agreement |  |  |

**Financial**

1. Describe your organization’s growth in subscribers during the past three (3) years. Include a schedule of annual additions and deletions to your covered lives and number of clients.

2. What percentages of the HMO’s total annual expenditures have been paid to related parties (i.e. subsidiaries, affiliates or parent company; joint ventures or firms in which you hold an interest Greater than 10%) for each of the past three (3) years.

3. What percentage of the HMO’s total annual expenditures for each of the past three (3) fiscal years are for the following:

Table 2 - Annual Expenditure Totals

|  | **2012** | **2013** | **2014** |
| --- | --- | --- | --- |
| a. payment to acute care hospitals (exclude out-of-plan providers) |  |  |  |
| b. payment to physicians or physician groups (exclude out-of-plan providers) not included in c., below |  |  |  |
| c. capitation payments to primary care physicians and/or groups. |  |  |  |
| d. specialty care (excluding (MH/SA) |  |  |  |
| e. payment to out-of-plan providers (e.g., out-of-state emergency and hospital services) |  |  |  |
| f. payment to providers for inpatient medical services for mental health, alcohol and substance abuse (exclude out-of-plan providers) |  |  |  |
| g. payment to intermediate care facilities, nursing homes, rehabilitation hospitals and other long term care providers (exclude out-of-plan providers) |  |  |  |
| h. payment to prescription drug vendors |  |  |  |
| i. payment for DM program |  |  |  |
| j. payment for CM program |  |  |  |
| k. payment for wellness program and |  |  |  |
| l. payment for healthcare results, quality outcomes, decreased burden of illness, reduced readmission rates, etc. (include any bonus pool or quality program payments here) |  |  |  |

4. Does your plan provide protection against the risk of insolvency by continuing benefit payments for the term of the agreement for which premium payments have been made or until members are discharged from inpatient facilities? If yes, describe the protection mechanism.

5. Provide your responses in the table below. What percent of your (a) gross revenue and (b) enrollment comes from the following sources? Percentages should total 100%.

Table 3 - Revenue and Enrollment Percentages

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Revenues** | **Enrollment (Lives)** |
| a. | Medicare |  |  |
| b. | Medicaid |  |  |
| c. | Employer Group accounts aaaccoaccouins |  |  |
| d. | Other (provide details) |  |  |
|  | Total | 100% | 100% |

6. Define and disclose administrative expenses, retention rates, medical loss ratio and profit margin for the last 3 years for which information is available. What percent and dollar amount of the Proposer’s book of business goes to patient care, to administrative expense and to profit?

7. List the following for each of your four (4) largest current clients; indicate the type of program you are administering as well as your term of service with each. Include the following:

A.)

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Start Date |  |
| Number of employees eligible |  |
| Number of employees enrolled |  |
| Number of Retirees enrolled |  |
| Number of covered lives |  |

B.)

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Start Date |  |
| Number of employees eligible |  |
| Number of employees enrolled |  |
| Number of retirees enrolled |  |
| Number of covered lives |  |

C.)

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Start Date |  |
| Number of employees eligible |  |
| Number of employees enrolled |  |
| Number of retirees enrolled |  |
| Number of covered lives |  |

D.)

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Start Date |  |
| Number of employees eligible |  |
| Number of employees enrolled |  |
| Number of retirees enrolled |  |
| Number of covered lives |  |

8. List the three (3) largest accounts that have terminated your services in the last 12 months. Include the following:

A.)

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Number of employees enrolled |  |
| Number of retirees enrolled |  |
| Number of covered lives |  |
| Termination date |  |
| Reason for termination |  |
| Description of all services provided to client |  |

B.)

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Number of employees enrolled |  |
| Number of retirees enrolled |  |
| Number of covered lives |  |
| Termination date |  |
| Reason for termination |  |
| Description of all services provided to client |  |

C.)

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Number of employees enrolled |  |
| Number of retirees enrolled |  |
| Number of covered lives |  |
| Termination date |  |
| Reason for termination |  |
| Description of all services provided to client |  |

**Provider Network Management**

1. Do you currently have an operational HMO network in the Chicago metropolitan area? If so, describe the provider network in detail and provide a map indicating the locations of the facilities. Provide a list of hospitals where HMO members can obtain services. Any directory information shall be provided in Excel format including the effective date for each provider, the provider name, the name and location and total excess capacity of the various outpatient facilities the HMO owns and or with whom it contracts.

2. Using the census provided by each Municipal Agency, provide a geo-access analysis of primary care physicians for the population. The geo-access report shall be provided for each Agency and shall provide detail on a zip code basis. The report shall detail the number of physicians available in the given zip code. The standard of access for purposes of the report is three (3) primary care physicians within five (5) miles and one hospital within ten (10) miles.

3. Attached as Exhibit IX is a listing of current medical practice groups that have been selected by Agency employees as their primary care physicians (PCPs). For each named entity, indicate whether your organization has a contract with the named entity to provide PCP services to HMO members and if you do, indicate whether the compensation is fee-for-service or capitation.

4. What is the percentage of Board eligible and Board certified physicians as compared to total physicians?

5. Describe the process and criteria you will use, both initially and ongoing to identify substance abuse and mental health providers who will be Providers within your network. Describe how you propose to evaluate the existing substance abuse and mental health Provider pool to provide covered services.

6. Describe your methods for capturing medical encounter data. Is submission of medical encounter data required? If not, why not? If yes, what methods do you use to ensure provider compliance with your requirements? What percentage of patient encounters are with:

Table 4 - Patient Encounter Percentages

|  |  |  |
| --- | --- | --- |
| a | Primary Care Physicians |  |
| b | Specialists |  |
| c | Nursing personnel; and |  |
| d | Other medical professionals (explain) |  |

7. Under what conditions may enrollees change physicians? What procedures must they follow and how often can a member change physicians.

8. What has been the turnover in primary care physicians for each of the last three (3) years? What is the percentage of primary care physicians whose contracts were terminated by the HMO in each of the last three (3) years? How many physicians/physician groups voluntarily left the HMO provider panel?

9. Describe how an employee or dependent that requires medical care while they are outside of the metropolitan Chicago area will be provided needed services. Example: a dependent who requires care over an extended period of time while away from home (student attending college). Do you have “guest” or “visitor” status programs for people who are temporarily domiciled outside of the service area? What are the terms and conditions of such programs?

10. What is your program’s policy regarding a patient’s continued treatment when their physician leaves the plan: If the answer differs due to either diagnosis or confinement status, explain. If an obstetrician leaves the plan, how is care for the patients in the third trimester of pregnancy handled? Do you have a transitional care protocol? Do your member hospitals use laborist physicians?

11. How does a member obtain a referral to receive services from a provider other than the member’s PCP? Who is responsible for obtaining any needed pre-authorizations? Are primary care physician referrals required for all specialty care? If not, to which specialists can a member self-refer? If the primary care physician refers to non-network provider without HMO approval, is the member responsible for charges?

12. Provide the HMO’s policy related to medical diagnostic tests (i.e., MRI, CT scans, PET scans, etc.) Are medical scans reviewed for appropriateness prior to the performance of the procedure? Why or why not? Who is responsible for the payment of scans?

13. Are there any medical services such as disease management, case management, wellness, fertility etc. that are subcontracted to another vendor? If yes, describe the services and the nature of the business relationship in detail.

14. Provide a description of how HMO physicians/physician groups may use nurse practitioners, physician assistants and other physician extenders. By what criteria is a patient referred to a physician assistant rather than a physician?

15. Do you utilize Urgent Care Centers? How does a patient access a provider for urgent or emergency care outside of normal business hours?

16. Do you allow patients to use the services of nurse practitioners located in retail pharmacies, big box stores, other locations for urgent/emergent care? Why or why not? If no, how do you ensure the member gets a timely physician appointment? Is a referral required? How are members informed of your policies with respect to these new sites of care? Describe such locations and list the locations in the Chicagoland area.

17. How do you notify enrollees of changes to the HMO provider network, e.g. new physicians and or new sites added; site terminations?

18. Describe how you will evaluate Provider sites to ensure that special needs populations have access to those sites and that sufficient sites are equipped to serve Enrollees with developmental or other disabilities. Describe the processes by which parents access medically necessary services for children who have diagnosed with autism spectrum disorders. Do you review to validate autism spectrum disorders? How are services determined to be medically necessary?

19. Do you have any contractual requirements that would ensure that diagnostic test results are available to the physician prior to a patient’s follow-up visit or requirements on how patients obtain test results?

**Compensation**

1. How are primary and specialty physicians compensated? Be specific. If you have a compensation plan for physicians, describe. Are there financial incentives to modify physician behavior? How does quality assessment affect physicians’ compensation?

2. Provide a sample contract for each type of provider, e.g. hospital, physician, etc.

3. Do you have a bonus or risk pool arrangement as part of the physician compensation package? What have the pay-outs been for the past three (3) years as both a dollar amount and as a percentage of the total eligible pay out? For those entities which contract on a full capitation basis, describe bonus or risk pool arrangements. Provide an illustration of how financial performance is determined. Also illustrate how surpluses and deficits are accounted for.

4. Explain your methodology for developing capitation rates for Physician only capitation and full capitation (all services) or other variants that is reflective of your contracting methodology. Specify those services that are included in the capitation payments. To what extent do you monitor the cost of services provided under capitation arrangements? How do you evaluate the cost efficiency of contracted providers?

5. Provide a listing of all hospitals with which the HMO contracts. Detail the fee arrangements for each hospital by service provided. How often are these contracts negotiated? What contracts are in place for non-hospital, non-physician services? How is the rate of increase in hospital reimbursement determined?

6. Do you base part of physician compensation on consumer satisfaction? If yes, describe criteria used to measure satisfaction. If not, why not? Provide the appropriate measurement criteria for other compensation factors? Do you base part of provider compensation on medical outcomes? If yes, describe criteria used to measure outcomes? If not, why not?

7. Is any part of compensation based on health improvement in the provider’s census? Provision of preventative services? What aspects of health care delivery do you believe are relevant to patients? Do your contracts reflect or require any of those items you believe relevant to patient satisfaction?

8. Do you allow providers with whom you contract to benefit from your contracts with your providers? For example, if you had a contract relationship with a prosthetics manufacturer and a PHO or physician group did not have such a contract, could the PHO or the physician group take advantage of any discounts or price reductions under your contract?

9. Attached hereto as Exhibit X is a listing of kinds of medical services. For each service indicate whether the service is included as a part of a capitated service contract with the physician/physician group. For purposes of this answer a service is included as part of a capitated service contract if the cost of the service must be paid by the physician/physician group and is not payable by the plan as a separate service on a fee-for-service or other basis. If the service category as described is too broad and you must adjust the category to accurately describe the contractual financial responsibility of the physician/physician group, please do do and take care in describing any limits/restrictions under the contracts.

10. Attached hereto as Exhibit XI is a list of provider groups (IPAs) from which Agency members have selected PCPs. To the extent that said provider groups are in your network, please rank said providers based on their capitated cost for:

* A single male 30
* A couple (male/female) age 40 and 37 and,
* A family (male/female) with parents 40 and 37 and children aged 7,5,13.

In order to rank said providers to rank said providers, develop an average annual capitation for each IPF then, using a weight of “1” for each provider, develop an average capitation amount for all represented IPAs in your network. Reset the capitation for each IPS as compared to the “average capitation” and rank the IPAs from highest to lowest relative to the average. As a result of these calculations, we would expect to see three relative pricing arrays (one for each listed unit directly above). For current vendor(s) please remove any IPAs that a particular Agency does not offer to its members and provide a custom assessment for that Agency.

**Credentialing**

1. Provide your hospital selection criteria. What criteria are used to recruit, select and credential physician providers and medical groups? Do you review a Provider’s practice history? Patient care results?

2. Do you credential providers in accordance with NCQA standards? Do you have a process for re-credentialing physicians? Describe in detail. Do your credentialing standards differ if the entity with which you are contracting is a PHO (Physician Hospital Organization) or other organizational form that provides the full spectrum of care?

3. Do you conduct on-site evaluations? Does your plan verify state licensure with primary sources; hospital admitting privileges; current malpractice insurance coverage and claim history? How often is malpractice information verified?

4. How do you evaluate provider performance? Describe your evaluation process. Have you established minimum performance standards? Do you maintain a corrective action process for providers? How does it operate? How many providers have been terminated for poor performance?

5. How do you make members aware of the results of your quality assurance and/or credentialing programs? If certain providers in your network perform less well than others on standardized measures, do you encourage members to select a higher performing PCP/group/PCP? Why or why not? What concrete steps have you taken over the last three (3) years to insure performance improvements by the lower performing physicians/physician groups?

**Systems Support/Technology**

1. Do you own or lease your major business systems? If owned, is it purchased, developed in-house or by an outside consultant? How is the system maintained, enhanced or upgraded? Describe the operational function the software supports.

2. The selected Proposer shall be able to process data from eligibility files provided by each Agency. Proposer should be capable of accepting the Agencies eligibility files through secure encrypted electronic transmission. Explain your capabilities. Indicate your ability to accept files in the EDI 834 format. If an agency provides a different format, please indicate your ability to accept a custom format. These eligibility files will be sent to you at least monthly, or weekly, (depends on Agency).How long does it take to update the eligibility information received in your system. Be specific as to time frames.

3. Skip

4. The Agencies prefers to send files that will contain all currently covered Subscribers. Also included will be records of recently terminated Subscribers; and these records will be clearly marked as terminations and will contain termination effective dates. Proposer should be able to process these terminations as quickly as possible, using the termination date provided. State your ability or capacity to process “full file” data and terminations. Describe your procedures for ensuring that terminated or non-eligible employees are dropped from benefit plans when their coverage ends.

5. Can you provide utilization data around the employee, spouse and dependents? The Proposer’s computer system shall be able to maintain eligibility at a dependent level. Provide screen prints from your eligibility system, demonstrating information stored at a dependent level. If a dependent is terminated, what impact does that have on subsequent transmissions? On reporting? Explain.

6. How long has your claims system been operational?

7. Describe your system’s hardware, operating system and application software. Where is the system located?

8. Provide a detailed history of significant systems and methodology changes and enhancements over the last two (2) years (or since system implementation if less than two (2) years). Include a description of your process to ensure all client edits are transferred.

9. For what time period of time do you maintain claims transactions on-line? What period of time do you maintain claims transactions in a machine-readable form, e.g., archived magnetic tapes or compact disks?

10. Do you have plans to significantly alter or enhance your claims administration capabilities? If so, describe.

11. Describe your system support, if any, for physicians writing electronic prescriptions.

12. For your five (5) largest clients during the past two (2) years, how many times have you: (a) changed processing systems requiring a history data transfer? (b) changed platforms? (c) changed time period for which history is kept on-line?

13. Describe your disaster recovery program and the procedures followed when your system fails. How quickly can the backup system be put in place? What historical or current data would be lost due to a power failure affecting the central system? How would lost files be recreated? Is any current day’s input lost if there is a power failure affecting work stations but not the central system?

14. If your telephone system fails, describe your disaster recovery program. Has your telephone system experienced an episode of down time which lasted more than twenty-four (24) consecutive hours?

15. Describe your computer security system. Who would have access to the Agencies data? What restrictions are there to computer access? Are passwords stored in an encrypted form? Are they changed on a regular basis? Where is the central system located? Describe the security of your Internet connected systems. Do you use firewalls?

16. When was the last time a system security audit was performed? If so, has the audit resulted in any deficiencies? If so, explain the nature of the deficiencies and whether or not the deficiencies were corrected. If the deficiencies were corrected explain the steps taken to correct the deficiencies and if not corrected explain why not.

17. The Health Insurance Portability and Accountability Act (HIPAA) mandate standards for Electronic Data Interchange transactions and code sets. What actions have you taken related to HIPAA security requirements? Enhancements?

18. Provide a specific description of your system’s ability to track work in process. Describe all information available to the Agencies and their customer service staffs.

19. How does your systems’ staff interact with your eligibility and customer service staffs? For example, if eligibility files have been received but not yet processed, how are service inquiries for newly eligible (but not processed) enrollees responded to? Who is responsible for processing changes in benefit design? What is the testing process to ensure any changes are accurate?

20. What reports are used to reconcile eligibility changes? Who prepares the reports? How are they used in eligibility processing?

21. Does your company’s system maintain the name and address of the carrier and/or health plan and an indication of a primary or secondary status? Is such status maintained for each covered person?

22. Describe your coordination of benefit capabilities with respect to Medicare coverage.

23. Has any component of your business systems or a business system with which you share data for any reason been subject to any breach or hacking events during the last five (5) years? If yes, please describe the event(s) and the steps your organization has taken to insure the safety of member data. specifically, what steps have you taken to improve the security of member ID, medical and claim information during the past three (3) years?

**Customer Support Services**

1. Describe any outside consulting organization(s) that assist you in any phase of the design, implementation or day-to-day operation of your HMO program.

2. Describe your customer service department, indicating the number of personnel who will be associated with each phase of implementation of the Agencies program from the inception through delivery of Services. Include a description of your telephone system, workflow patterns and management structure. Also advise us as to whether you will have a dedicated customer service unit and/or line(s) for each of the Agencies and if there will be an additional charge.

3. Do you offer special programs or services for retirees (Medicare eligible persons)? If so, describe.

4. Do you provide toll free numbers for clients and Subscribers? What are the days and hours of operation? How many full time customer service representatives would be provided to service the Agencies’ accounts? Do you provide emergency telephone service during all other hours? If so, what it the nature of the service that is available? If no emergency telephone service is provided, why not?

5. How often can your staff answer a telephone request on the first call, versus how often your staff has to call back? Indicate how you insure callbacks are made? What are the results that you have achieved for your telephone customer service units in the last 6 months with respect to:

1. abandonment rates;
2. busy signals;
3. average time in queue; and
4. average call time.

6. Does your organization provide a customer service “hot line” for urgent inquiries regarding benefits? What are the “hot line” customer service hours? Who is given access to this service? What reports or controls do you have regarding the quality of this service (including monitoring enrollee satisfaction, relative to promptness, courteousness, and accuracy) that your customer service unit provides?

7. Provide an overview of your process for complaint handling, including a description of the formal process and ways in which complaints are used for corrective action. Include in your discussion complaints originating from clients, Subscribers, providers and staff. Provide a statement of how you expect to resolve: a) employee complaints; b) provider complaints; and c) Agency complaints. Will this procedure differ for out-of network providers? What are the two most common areas reflected in these complaints?

8. Describe the grievance procedure in detail for the subscriber, for the provider and any role the Proposer would expect the Agencies to take in the procedures. Indicate whether the grievance procedure includes an appeals board comprised of all interested parties (i.e., employee, employer (Agency), clinicians, health plan representatives) that meet periodically to resolve grievances and make recommendations regarding improvements to patient care and administrative processes

9. Do you have an established member complaint log for both administrative and clinical problems? Describe the procedure for providing feedback to the employer. Also provide the following statistics:

Table 5 - Grievances and Denials Log

|  |  |  |
| --- | --- | --- |
| **Issue Type** | **2013** | **2014** |
| **Number of grievances submitted in the last two (2) years** |  |  |
| **The subject of grievances (e.g., provider courtesy, quality care, promptness, claim denial, accuracy, etc.)** |  |  |
| **Results of the grievance process by subject in the following categories:** |  |  |
| **Denials upheld** |  |  |
| **Denials modified** |  |  |
| **Denials overturned** |  |  |
| **Other** |  |  |

10. Provide the results of any member surveys conducted by the HMO over the past two (2) years.

11. Indicate under what conditions a Subscriber could be terminated from coverage by your organization.

**Plan Administration**

1. The Agencies expect to be billed no more frequently than monthly. At a minimum, the Agencies will require that the invoices contain the following information: Indicate Y or N as to whether invoices will contain this information:

Table 6 - Invoice Details

| **Invoice Detail** | **Yes** | **No** |
| --- | --- | --- |
| Group number |  |  |
| Enrollee social security number or unique identifier |  |  |
| Enrollee name |  |  |
| Patient name and relationship to employee |  |  |

2. The Agencies will routinely provide the enrollment information via electronic transmission. Enrollment and termination information for Public Health Service Act (PHSA) participants is provided on paper. A full, positive census of PHSA enrollment and termination data is provided on a weekly basis. Describe how you would update eligibility for PHSA participants. Describe your quality assurance controls for eligibility screening.

3. How would weekly full-file refreshes be processed?

**Monitoring and Reporting**

1. The Agencies may require specific reports. What are the standard utilization activity and management reports that you would provide at no additional costs. What would be the frequency of this reporting? Can an Agency design its own reports?

2. Proposer shall provide a complete package of monthly, quarterly and yearly management and utilization reports on CD Rom. Indicate whether you have the capacity to generate the following reports by Agency. Include a sample report package for a specified period.

1. R&C savings, which lists number of charges received, number of charges reduced, percentage of total, total charges received and amount saved.
2. Claims distribution, which lists the number, percent of total, average charge and average paid.
3. Benefits summary, which lists charges, ineligible amounts, basic deductibles (if applicable) co-insurance, COB credits and amounts paid.
4. Audit savings, which separately lists charges and savings from bill review and specialist fee review due to audit findings. Be specific as to how savings were achieved.
5. Number of enrollees who received no services from an HMO provider during the reporting period.
6. Name of provider
7. Co-payment revenue collected by providers from Municipal Agency enrollees
8. Cost of service provided to member
9. Gross and net charges
10. Third Party Recoveries, which lists participants, claimants, total charges and total recoveries for each incident caused by a third party.

3. Will you provide reports that can be compared to national and industry statistics and project future trends based on the Agencies past utilization data, enrollment?

**Claims Processing/Third Party Liability**

1. The performance standards for claims processing which includes: volume, claims turnaround time, financial (payment) and procedural accuracy is 98%, 99% and 98% respectively. Can you meet these standards? If so, what do you propose? What is the average turnaround time to process claims? How do you define turnaround time? Explain, using the following:

1. 90% of claims processed and sent within \_\_\_\_\_\_business days of receipt;
2. 99% of claims processed and sent within \_\_\_\_\_business days of receipt; and
3. investigated claims (claims pended for investigation (i.e. reimbursement requests for repeated tests) by claim adjudicators processed within business days of receipt.

2. What aspects or areas of each claim do you investigate? What claims require a separate supervisory authorization prior to payment? How do you flag accident related claims to avoid duplicating medical coverage? Will your system identify any procedures that are being repeated or any indications of unusual patterns of treatments or non-compatible services?

3. How do you assure that turnaround time will be maintained during periods of heavy utilization or turnover in staff and during transition from an existing vendor?

4. Do you subcontract any part of your claim processing operations? If yes, would you use a subcontractor on the Agencies claims? If yes, who is the subcontractor?

5. What percentage of claims is pending because they require additional information for processing? If a claim is received with missing information, explain how it will be handled.

6. What are the minimum data fields required to process paper claims?

7. What are your procedures for handling denied claims? Describe the procedures you have in place to track the timeliness of a denial. Will you send denied claims with explanations back to Subscribers? If so, explain the process. Provide a copy of an Explanation of Benefits (EOB) and a list of applicable denial messages.

8. What documentation do you maintain for outstanding information or follow-up requests? How do you follow-up these requests? Is tracking system based?

9. Can your claims processing system accommodate special plan design features that the Agencies may require?

10. What is the address(es) of the claim processing location that would process the Agencies claims?

11. Provide claim adjudication statistics for the proposed claim processing location.

Table 7 - Claim Adjudication Statistics

|  | **Your Standard** | **2015 Results** | **2014 Results** |
| --- | --- | --- | --- |
| Financial accuracy (percent of dollars paid correctly). |  |  |  |
| Overall accuracy. (average payment incidence accuracy) |  |  |  |
| Percentage of “clean claims” completed in 15 calendar days. |  |  |  |
| Percentage completed in 30 calendar days. |  |  |  |

12. How do you process out-of-network claims? Do they go through the same processing edits as network claims? If not, what are the differences? Do you have experience in working with a medical claims payer to coordinate data on out-of-network retail claims for inclusion in calendar year deductibles and annual out-of-pocket accumulators? If so, describe how this interface works. Is there a cost for this service? If yes, what is it?

13. Confirm dental coverage regarding accidental injury is included within the network or program option. Certain dental procedures are covered under some of the Agencies HMO programs such as accidental injury to sound natural teeth and or bony impacted wisdom teeth. Do you offer a network of dentists and/or oral/maxilofacial surgeons for these purposes?

14. Does your system maintain historical information on submitted expenses and paid claims? How long is this claim history maintained on-line? What system controls do you have in place to avoid paying duplicate claims submitted at the same time, or at different times? Explain how your system identifies duplicate charges.

15. Provide a flow chart diagramming how claims will be processed including control procedures, estimated time frames from initial receipt of claim through pending, final resolution, issuance and mailing of payment and/or explanation of benefits (“EOB”).

16. How do you define errors in claim payments? Do you have an on-line documentation system to monitor and track inquiries for both individual follow-up and closure as well as trend analysis over time? How will you insure that the claim payment for the treatment of a given medical condition represents payment of the least costly, effective form of treatment? Explain.

17. Under what circumstances may the provider bill the patient directly for any portion of the services provided?

18. Explain in detail your procedures for Coordination of Benefits (“COB”)

1. Describe how COB accumulators function
2. Are all services subject to COB, or only those above a certain dollar level?
3. Explain your internal procedures for detecting and handling such claims
4. Does your system require an affirmative override action to pay new claims after COB had been previously involved?

19. How do you allocate recoveries back to the account, particularly if premiums are based on experience?

20. Are there limitations on services related to the diagnosis or treatment of chronic illnesses? If so, provide details. Provide a sample of the monthly claims summary that would accompany your invoices.

21. Describe your ability to archive and retrieve claim files for up to seven (7) years.

22. Give a precise explanation of your methodology for the calculation of the incurred but not reported (“IBNR”) claim reserve.

23. Will you allow a claim audit by the Agencies’ vendor of choice? Will you allow the Agencies to pull statistically valid sampling (number of claims) for review? Will you allow the Agencies to recover based on the results of an audit for extrapolation?

24. Provide the guidelines you use for determining Reasonable and Customary (“R&C”) charges for providers who are not in your plan’s network. How often are these R&C files updated? What is the data source for these amounts?

25. Describe your third-party liability recovery program. Describe your administrative procedures for identifying such claims and provide your methodology for processing. Do you use an outside source for third-party liability? If so, please identify and advise if you would use this subcontractor on the Agencies account? How are they compensated? Describe the success of your program and provide the following data for your book of business for the last three (3) years.

26. If the Agencies or an Agency requests, will you use another subcontractor for subrogation and third party liability recovery? If the Agency already has an established relationship with a vendor for these services will you work with that vendor without additional charge?

**Data Requests**

1. Indicate the number of clients to whom the HMO provides services.

2. For your five (5) largest employer groups, indicate clients with:

1. employee population greater than 25,000
2. employee population greater than 25,000 with collective bargaining agreements
3. governmental employee populations (5 largest governmental groups)

3. For your book of business, provide the following:

1. mortality rate per 1,000 enrollees
2. the number of medical malpractice claims made by members in the past two years
3. the number of medical malpractice awards made to members in the last two years

4. Provide the following statistics with supporting documentation for the last three (3) calendar years for non-Medicare primary enrollees:

1. Admission rate per 1,000 members
2. Inpatient days per 1,000 members
3. Outpatient encounters per 1,000 members
4. Average patient length of stay for medical//surgical, pediatrics and ob/gyn.
5. Average length of stay for mental health & substance abuse
6. Overall average length of stay.
7. Number of inpatient surgeries performed per 1,000 members.
8. Number of outpatient surgeries performed per 1,000 members.
9. Number of physician contacts per member per year.
10. Number of specialist physician contacts per member per year.

5. For network hospitals, indicate which provide inpatient care, provide the following items for the last three (3) calendar years:

1. number of admissions
2. number of inpatient days
3. average length of stay
4. percentage of total HMO admits; and
5. average cost per admit (actual cost to the HMO not billed charges)

**Mental Health/Chemical Dependency Programs**

1. Does your organization out-source Mental Health/Chemical Dependency care? If yes, to whom? Identify the essential staff members in your organization and the sub-contractor organization who will be responsible for the administration of the program.

2. Provide a current list of participating mental health/chemical dependency providers by specialty. Provide a geo-access analysis based on two (2) providers within five (5) miles using zip codes provided in Exhibit VIII Agency Census cd. The geo-access report shall provide detail at the zip code level for Chicago, and shall include the number of providers in the zip code.

3. Describe the quality assurance program in place to monitor your mental health/chemical dependency providers and the health services they render. Who performs utilization management services?

4. What standards or criteria are used to determine appropriateness of admission, length of stay, treatment protocols, additional inpatient days and/or outpatient visits for psychiatric chemical dependency and detoxification treatment? Does the criterion used to certify psychiatric and chemical dependency hospital admissions for adults and adolescents differ?

5. What criteria do you apply for autism spectrum disorders? What criteria do you apply for Applied Behavioral Analysis (“ABA”)? Are services provided under the state mandated benefit tracked? How? Who is financially responsible for these services? Do you have contracted providers for ABA?

6. Describe your appeals mechanism when the patient disagrees with any utilization determination made by your organization. When the attending physician disagrees?

7. What is your procedure when a dual diagnosis (both psychiatric and chemical dependency) exists? Describe what criteria you use to determine medical necessity and appropriateness of care for such cases.

8. How is aftercare handled? Provide details. How are alternative facilities or vendors selected? How are they monitored and how often?

9. Describe in detail your procedures for establishing and maintaining a network of treatment providers and programs for persons covered under your MH/CD programs.

10. Describe any protocols you have for prescribing psychiatric drugs. Do you allow all physicians to dispense such medications?

**Utilization/Medical Review**

1. Provide a narrative describing your Utilization Management Program plan description, as well as its functions and responsibilities, and how you exercise these responsibilities, including criteria used and any special issues in applying Utilization Management guidelines. Describe how your UM program detects, monitors and evaluates under-utilization, over-utilization and inappropriate utilization of services as well as processes to address opportunities for improvement.

2. Describe the components, philosophy and processes for each of your review programs. Include a flow chart indicating the professional qualifications of the staff involved at each level of the process, including prior authorization and decision-making. Provide a narrative description of your prior authorization processes. Provide an estimate of the percentage of cases which are reviewed at each review level for your book of business and the results of those reviews.

3. How do you determine whether a prescribed therapy is unnecessary or inappropriate? Do you review high tech outpatient procedures such as MRI’s/Cat scans and Pet scans for medical necessity? If no, how do you monitor utilization of services? Are medical outcomes measured and tracked? If yes, how? If no, explain.

4. How is quality assurance data used to improve performance?

5. Describe your methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity in accordance with UM policies and procedures, and at a minimum include:

1. Pre-admission certification process for non-emergent admission;
2. concurrent review program to monitor and review continued inpatient hospitalization, length of stay or diagnostic ancillary services regarding medical necessity;
3. admission review of urgent and/or emergency admissions; and
4. reviews of same day surgery procedures.

6. Describe the criteria you use in determining medical necessity, substantiating that the criteria is objective and based on medical and/or behavioral health evidence.

7. On what basis does the organization determine a procedure to be experimental or investigational? Have you ever made exceptions and provided coverage on investigational or experimental procedures?

8. How do new transplant procedures become covered services?

9. Describe how you identify and treat high risk patients.

10. What does the plan do to assess coordination of care between providers and institutional settings?

**Grievance and Appeal Procedures**

1. Do you have an established procedure in place for reviewing grievances registered by enrollees? Explain the process.

2. Do you have an established procedure in place for reviewing Appeals made by enrollees or providers on behalf of enrollees? Explain the process.

3. Do you have a complaint and resolution system in place for Providers that includes a Provider dispute process? Explain the process.

**Quality Assurance/Review-HMO**

1. To what extent, if any, do you survey enrollees to determine their comprehension of and satisfaction with your program? Do you track and report on disenrollment rates? Conduct post-termination member surveys? If yes, how do you follow up on the results of post termination member surveys?

2. Describe your Quality Assurance/Review process, detailing the procedures in place for establishing, maintaining and evaluating the HMO. By what mechanism do you ensure that provider financial incentives do not compromise the quality of medical treatment?

3. Describe your program for peer review and on-going quality of care assessment and monitoring of each of the following provider types:

1. Physicians;
2. nursing personnel;
3. ancillary service providers;
4. psychiatric service providers;
5. hospitals and
6. other inpatient facilities.

4. Provide the names and qualifications of the individuals who perform the reviews and how frequently they occur, indicating the methods and standards used to check; a) subscriber fraud and abuse; b) appropriateness of care; and c) up-coding or unbundling.

5. Describe and (internal and external) audits conducted by the HMO to maintain the integrity of the HMO and its operations. Describe your accuracy standards with regards to pre-payment and post-payment reviews. Who conducts internal audits and how often are they conducted? Are clients provided information regarding the internal quality control audit reports?

6. Do you develop utilization profiles for your providers? Describe your use of such profiles for monitoring under and over utilization of medical services and diagnostic tests. How many physicians have you identified as under or over-utilizing diagnostic tests in the past year? What course have you taken?

7. Describe the five (5) most important actions your plan has taken in the last year to improve:

1. quality of medical services;
2. financial performance;
3. customer service.

8. Describe how you evaluate a physician’s practice patterns. What important aspects of care are being monitored and evaluated on an on-going basis? In which areas does your plan perceive problems? Do you provide comments to physicians on results from practice pattern analysis? Do you provide individual comments, peer comparisons? Continuing education? Cost and financial information?

9. During the past two years, have you conducted any studies of the health status of members? For your book of business? For a particular client? If yes, describe. If you have done aggregate or client specific health assessment studies, what actions have you taken as a result of your analysis of the collected data? Have you modified any HMO practices? Initiated disease specific programs or protocols?

**Performance Standards and Guarantees**

Table 8 - Service Level Requirements

| **Service Performance Standards** | **Standard** | **Guarantee** |
| --- | --- | --- |
| 1. Plan Implementation | Complete according to Implementation timeline | HMO will reimburse Agencies for the full amount at risk no later than the end of the first quarter of the year of the inception of the contract, if any one of the key milestones is not met due to a failure on the part of the HMO |
| 2. Network Size | 99% of all Agency Subscribers shall have access to at least two network facilities within 5 miles of their residences during normal business hours; | To be measured by Geo  Access reports produced by the Contractor annually for each Contract. For each full percentage point below the standard, the Proposer will be pay liquidated damages of 5% of the fees associated with this activity. |
| 3. Network System downtime | Proposer shall agree that system down time will be no greater than 2 hours per incident; not to exceed two times per Contract year. | Liquidated damages to be assessed at time of violation at a flat fee of 5% of applicable fee for the month, per occurrence; further, any paper claims processed due to system downtime will not be charged to the Agencies. |
| 4. Reporting  Requirements | Proposer shall agree to provide all the reports specified in this RFP within the stated time periods, and to provide the on-line query capability described in the Proposer(s) response. | Failure in any month to provide  The required reports will result in liquidated damages of 5% of the applicable fees to be deducted. |
| 5. Desk Audits |  | Failure in any month to provide  The required reports will result in liquidated damages of 5% of the applicable fees to be deducted. |
| 6. On-Site Audits | Proposer shall agree to perform on-site audits for at least the top 10% of providers that are identified as outliers, pursuant to the desk audits, in each year of any Contract. | Failure to perform these audits will result in liquidated damages of 5% of the applicable fees. |
| 7. Call Answering Time | 95% of all calls received will be answered within 30 seconds. | Failure in any month, to meet this standard will result in liquidated damages of 5% of the applicable fees to be deducted. |
| 8. Call Abandonment Rate | No more than 3% of calls may be abandoned. | Failure in any month, to meet this standard will result in liquidated damages of 5% of the applicable fees to be deducted. |
| 9. Claims Processing & Accuracy |  | Failure in any month, to meet this standard will result in liquidated damages of 5% of the applicable fees to be deducted. |
| 10. Prior Authorizations | All requests for prior Authorizations shall be acted upon within 72 hours |  |
| 11. Security breach | No security breach during the term of the agreement or for seven (7) years following termination. | At no cost to the member or the Agency, the proposer will make available a package of identify protection services for two (2) years following the close of the year in which the breach occurred. |
| 12. Formulary Rebates | Proposer shall agree that any payments resulting from the formulary rebate process and all Rebate reporting will be made within 60 days of the receipt of payment from manufacturer. Reporting shall describe the source of the rebate by BDC and date payment was received from manufacturer. |  |

**Qualitative Questions & Additional Concerns**

1. How do you distinguish yourself from your competitors? Why should the Agencies select your organization? If you are selected to offer services to Agency employees beginning January 1, 2016, how will you insure that they:

1. Understand their benefits;
2. Participate in wellness and disease management programs;
3. Take an owner’s interest in their health.

2. What specific steps are you taking to improve provider performance in the areas of health status management, financial performance and quality of care?

3. Using the Agency’s claim data, provide your examination of their current utilization and compare their performance against your broader book of business.

4. Carrier data integration options and the associated cost. Specifically discuss your ability to perform bi-lateral, real-time out-of-pocket maximum accumulator Integration with medical carriers starting in 2016.

5. Describe your commitment to the public employee market.

6. What is your definition of a never event? Do you reimburse your providers for never events? Do you use Medicare’s definition, or have you created your own?

7. Do you engage in predictive modeling to identify potentially at risk patients? If yes, how are the results of the profiling shared with providers and patients. What software do you use to conduct such analyses?

8. As earlier stated, indicate in writing your understanding that upon termination of any contract for whatever reasons, the claims run-out is the period of time after the plan year has ended for the participant to submit claims for reimbursement. That period of time is no less than 1 year or 12 months after the end of the plan year.

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EXHIBIT XVII -A

**CITY OF CHICAGO ONLY AGENCY**

**INTERROGATIVES FOR PRESCRIPTION DRUGS**

**Pharmacy Benefit – This section is for the City only:**

The goals of this program are:

1. To effect positive changes in the delivery system while continuing to provide appropriate benefits and ensure that drug programs are within our budget guidelines and administered effectively, efficiently and responsibly at the lowest possible cost. The successful Respondent will demonstrate its ability and willingness to work with both retailers and drug manufacturers in finding the most effective ways to control costs.

2. To develop and disseminate consistent information to employees and their dependents that is consistently accessible.

**General:**

1. Describe your prescription drug infrastructure including whether the program (retail, mail and specialty) is done in-house or subcontracted to another vendor. What organization will you use to provide PBM services to HMO members? How long have you (the respondent) used that organization to offer PBM services to HMO members? Is the PBM a related or affiliated organization? If yes, what percentage of ownership do you hold? NOTE: For all the following questions in this section on Prescription Drug Coverage, the use of "you" is meant to apply to the PBM unless in context it clearly means the respondent rather than the sub-contracted/affiliated PBM; or, if the Respondent has adopted programs which supersede or substitute for the PBM programs, then so indicate in the response to the question. The City wishes to understand which entity is responsible for each aspect of prescription drug coverage and the management of prescription drug services for its members. If you feel that an overview description delineating which services are provided by each entity would help the City understand your program better, please provide that overview.

2. For how many lives does the PBM provide prescription drug services? For how many employers during 2014; how many prescriptions were dispensed?

Please complete the table below with the total number of covered lives and processed claims for the past three (3) years.

Table 9 - Total Retail / Mail Processed

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | 2013 | 2013 | 2014 | 2014 | 2015 | 2015 |
|  | Retail | Mail | Retail | Mail | Retail | Mail |
| # of Employers |  |  |  |  |  |  |
| # of covered lives |  |  |  |  |  |  |
| # of scripts filled |  |  |  |  |  |  |

3. Provide four references for accounts of similar size to the Agency accounts. Provide contact

information so that if the Agency wishes, it can ask about your performance on their account.

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Start Date |  |
| Number of employees eligible |  |
| Number of employees enrolled |  |
| Number of covered lives |  |

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Start Date |  |
| Number of employees eligible |  |
| Number of employees enrolled |  |
| Number of covered lives |  |

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Start Date |  |
| Number of employees eligible |  |
| Number of employees enrolled |  |
| Number of covered lives |  |

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Start Date |  |
| Number of employees eligible |  |
| Number of employees enrolled |  |
| Number of covered lives |  |

4. Provide four accounts of similar size to the Agencies that have terminated services with the PBM and indicate the reasons for termination.

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Number of employees enrolled |  |
| Number of covered lives |  |
| Termination date |  |
| Reason for termination |  |
| **Description of all services provided to client** |  |

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Number of employees enrolled |  |
| Number of covered lives |  |
| Termination date |
| Reason for termination |  |
| **Description of all services provided to client** |  |

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Number of employees enrolled |  |
| Number of covered lives |  |
| Termination date |  |
| Reason for termination |  |
| **Description of all services provided to client** |  |

|  |  |
| --- | --- |
| Organization Name & Address |  |
| Contact Name and Title |  |
| Telephone Number  E-mail address |  |
| Number of employees enrolled |  |
| Number of covered lives |  |
| Termination date |  |
| Reason for termination |  |
| **Description of all services provided to client** |  |

5. Discuss the financial relationship between the PBM and the HMO. Does the HMO intend to retain any sums related to the prescription drug activity? If so, for what services/drugs and what would be the expected retention per year for each of the three years of the initial term of the contract with the HMO? Provide the percentage of total revenue that the PBM represents to your organization.

**Plan Design**

6. Do you maintain a current and accurate drug file that is updated in a timely manner? Which service do you use for pricing purposes? With what frequency is the pricing file updated?

7. Do you maintain a prescription drug formulary? Describe your process for establishing, maintaining and monitoring your formulary. How often is your formulary changed? Describe the process by which drugs are considered for inclusion in the formulary. Describe the educational and professional requirements for an individual to participate in your formulary setting panel/process. Do members have relationships with drug manufacturers?

8. How is the patient affected if the physician prescribes a non-formulary drug? Does your plan cover non-formulary drugs? What is your process to consider an exemption to the formulary dispensing requirements in the employer plan?

9. Describe your programs available that would encourage the use of mail order services. Of your book of business, what percentage of drugs dispensed in 2013 and 2014 were dispensed at retail, mail order and from the specialty pharmacy?

10. Do you make the most current formulary drug lists available on the web? How do you communicate preferred drug lists changes to providers and members?

11. Briefly describe the programs available to monitor, measure and influence physician-prescribing habits. Are your participating physicians allowed to prescribed any legend drug? If no, what are the prescribing limits? Provide an example of educational materials or other monitoring tools used to influence prescribing behavior and to educate prescribers. Include the effectiveness of each of these examples and how outcomes were measured.

12. Does the HMO program include quality or performance measures related to the dispensing of prescription drugs? If yes, what programs are in place for 2015? What programs were in place for 2014? Provide results for 2014 that include data related to what the goals were and how many physician groups achieved full results and partial results. What would be a typical payment for full compliance? Partial compliance?

13. Describe in detail your organization’s paper claims tracking/processing/adjudication system and processes for non-network pharmacy services. Include how claims are handled where the form is incomplete or not in the standard format. Are you able to accept, adjudicate and track paper claims in a timely and efficient manner? Pharmacy claim transactions? How are prescriptions covered if the member gets prescriptions from an out-of-network pharmacy or physician?

14. Do you have a fraud and abuse program and/or audit process? Does your organization have an audit process for high dollar claims? Describe your fraud and abuse programs and provide information on how successful the programs have been in the last two years (2013 and 2014).

15. As new drugs are approved by the FDA, can they be immediately prescribed for enrollees? If no, what is the process by which they are included or excluded?

16. The City has negotiated a variety of co-payment and co-insurance structures with their various unions for the HMO drug benefit. Review all prescription drug plans and confirm that you can administer the plans as written. If you cannot administer all terms exactly as written, specify that term in writing and explain why you cannot administer the provision.

17. What effect does the enrollee co-payment have on utilization? On formulary performance?

18. The City’s prescription drug benefit program requires that if a patient elects a brand drug when the generic is available, the patient must pay the difference in costs between the brand and the generic plus the co-payment. Can you administer this?

19. List each DAW code and describe how you would administer the DAW code in the context of the City's benefit plan, including information on how the account would be charged in each instance. Assume for purposes of your example that a brand was dispensed when a generic was available.

20. For purposes of any plan payment rule that includes language "when a generic is available" when do you consider a generic to be available? When there is one generic equivalent? Two? More?

21. Under your most common HMO product offering subject to ACA rules related to birth control, which birth control devices and/or forms do you cover? Separately list those products in response to this question.

**Mail Order**

22. At what percent of total capacity is the mail order pharmacy currently operating? How much new volume is expected to be added in 2015?

23. Are all mail order claims processed online, real-time through the PBM administrative system?

24. Does the mail order pharmacy provide its own customer service unit or is this responsibility provided by a separate customer service unit?

25. What is your mail order pharmacy prescription filling error rate? How do you manage the error rate to the lowest possible? Does the mail order pharmacy track internal errors (not leaving the facility) separately from external errors (those that did leave the facility)? How do you handle internal and external dispensing errors when they occur?

26. Does the mail order pharmacy offer voice response and/or Web site ordering and order tracking?

27. How do you handle PBM DUR messages when they are presented to the mail order pharmacy staff during the handling of a prescription order? Does the staff document their action from these messages?

28. Does your mail order pharmacy perform “drug substitution” on targeted brand and generic medications? How are drugs selected for inclusion in the drug substitution process?

29. Are your CSRs instructed to recommend use of the mail order pharmacy to members with new prescriptions or when discussing with the member claims submitted by network pharmacies?

**Retail Network**

30. How many pharmacies are in the bidder’s network nationally? Describe your network pharmacy credentialing process.

31. What latitude does the service staff have to resolve claim edit questions from providers?

32. Do you provide network pharmacy audits? Are these desk audits or onsite audits? How do you audit for network pharmacy contract compliance including their proper handling of DUR messaging?

33. How do you grade the performance of network pharmacies, both financial and service performance factors? How do you use this data to enhance network performance?

34. How do you inform the network pharmacies of new generic items when they become available? How do you manage the network to the highest performance in this area?

**Pricing**

35. If your price proposal includes a MAC basis, describe the process by which you develop the MAC pricing amounts. Do you offer voluntary, mandatory or incentive based MAC programs? Describe how patients are informed about and impacted by such programs. How often are the MAC prices updated? Provide an electronic file of the NDC numbers affected by your MAC pricing along with the package quantity and your current unit MAC price for that NDC number.

36. How would a member access diabetic supplies? Do you limit dispensing to a particular manufacturer’s products? Do you provide glucometers? If yes, at what cost to the member? Do you have a relationship with a manufacturer for glucometers that transmit readings via wi-fi when they are taken? Are you considering such a relationship?

37. Are flu shots covered for all members? If not, how are they covered? Are they covered as part of the pharmacy benefit or the medical benefit?

**Quality Assurance**

38. Describe your organization’s quality assurance process to assure accuracy of the application of the drug pricing file and the claims processing and ancillary systems proposed.

39. Explain your contractual relationships with the drug manufacturers. Identify all types of revenue sharing, rebates, administrative credits, etc.

40. Describe the process by which drug utilization is monitored. How do you analyze physician prescribing patterns?

41. When a drug goes over the counter, do you continue to pay for that drug if it is prescribed in the same strength/dosage form as is available over the counter? Why or why not? Describe how your organization dealt with the introduction of Nexium over the counter. Did you stop paying for the drug when it was prescribed in the same dosage form as available over the counter?

**Specialty Pharmacy**

42. Describe your specialty drug management programs in detail. Which drugs are subject to the specialty program? Given the expected increased utilization of specialty drugs over the expected term of the contract for HMO services, describe how your programs related to specialty drugs will help the City insure that their specialty drug spending is appropriate and necessary.

43. Provide your list of Specialty drugs and the associated discount and dispensing fess costs. How are drugs added to the specialty drug list? Who decides whether a drug is added? What factors are considered when a drug is evaluated for addition to the specialty drug list?

44. What is your expectation of the aggregate trend increase for drugs over the next four (4) years? For generic drugs, brand drugs and specialty drugs considered separately? Are you taking any steps to reduce the expected trend? Why or why not?

45. Develop expected prescription drug rates for the next four (4) years, using your assumed trend and assuming the co-payment schedule in the Schedule of Benefits provided with the RFP Exhibits. Determine what percentage of the projected medical loss ratio is attributable to prescription drugs. Do you see general medical (non-pharmacy) expense increasing or decreasing as a result of the expected increased dispensing activity? Why or why not?

**Network Management**

46. How will you manage physician prescribing behavior over the next four (4) years? Do you expect to manage prescribing behavior any differently in four years than you do today? Why or why not? Do the PBM and HMO management confer on these issues? Which entity retains responsibility for prescription drug services management?

47. What drugs require pre-authorization? What is the process to clarify information on a prior authorization request? Will you support prior authorization requests and appeals through the customer service call center, handling initial prior authorization requests within twenty-four (24) hours of receipt? Are physicians and pharmacists involved in the prior authorization approval and denial process? How are members and physicians notified of prior authorization approvals and denials? Does your organization have a “Provider Relations” department for pharmacies? Are all drugs which require prior authorization considered to be specialty drugs?

48. Do any special protocols apply to self-injectable drugs?

49. Do you monitor expenses related to chemotherapy to determine the appropriateness of the usage of chemotherapy drugs? Do you review such billing to determine if an appropriate quantity of drugs was billed? Are drugs for chemotherapy part of the prescription drug benefit or the medical benefit?

50. The City may wish to carve-out the prescription drug benefit to a preferred vendor. Do you have any objections to this? If so, what are they? Do you see any downside to this outsourcing? If you have physician payment incentives related to prescription drug dispensing, would this change those incentive payments or have an effect on medical management?

51. Does your organization contract directly with the pharmacy network or is it subcontracted? If subcontracted, to whom? What are the requirements for a pharmacy to participate in your network? How often do you credential pharmacies/pharmacy chains? During the past two years have you removed any pharmacies from your network? For what reasons?

52. Do you conduct on-site audits of pharmacies? Under what circumstances?

53. Do you have any criteria related to the dispensing of opioids? If yes, what are they?

54. Is the cost rate you debit the client experience the same amount that you pay for drugs? Are clients’ accounts credited with prescription drug rebate amounts? If yes, what amount? Is this amount the total amount of the rebate received for the drug? If no, why not? Will you agree to pass-through (one-hundred) 100% of the retail network provider discounts, to Maximum Allowable Cost (MAC) rates and dispensing fees, and not retain a margin or “spread” on any of its retail pharmacy reimbursement contracts? Will you transmit paid claims data to the rebate vendor on at least a weekly basis?

**Reporting**

55. Are you able to integrate medical and drug databases in order to identify disease states and patient population for disease management programs and to measure outcomes? Do you identify under and over utilization of prescription drugs and share that information with the Primary Care Physician? Why or why not?

56. How do the reports that you provide to Primary Care Physicians on the use of prescription drugs assist the PCP in management of care? Provide sample reports on prescription drugs that are provided to PCPs.

57. Describe the safety, age, gender and quantity edits that are applied to dispensing activity.

58. Provide a sample reporting package for prescription drug services.

59. If the City uses another vendor for prescription drug services willing to provide you (the HMO) with prescription data on a regular basis for your use in performance review and management of patient care, would you accept that data and integrate it with other data you have on hand? Why or why not?

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EXHIBIT XVIII

**AGENCIES’ GOALS AND RESPONDENT’S OFFER**

The Agency(s) shall adopt the offers into the Scope of Work, as may be applicable. Please include separate sheets if providing additional comment.

| **Agencies' Goal #** | **Respondent's Offer** | **Check √ if Shall Provide** | **Check √ if Shall Not Provide** | **Comment** |
| --- | --- | --- | --- | --- |
| 1 | To designate an implementation manager who shall be accountable for the overall success of the Plan, including identification of designated implementation team to develop and execute a detailed Plan and conduct weekly implementation meetings. |  |  |  |
| 2 | That in no case may Services be offered except by persons and firms authorized and duly licensed as required by federal, state and/or local laws or regulations. The Respondent must provide evidence of a license to do business in the State of Illinois, and all other licenses and certifications as may be necessary to provide the Services requested. Additionally, such persons and organizations shall be insured in accordance with the insurance requirements specified by each Agency per Exhibit IV. |  |  |  |
| 3 | To offer such Services in conformance with applicable federal and or state laws and regulations, the Agencies' ordinances, personnel policies, procedures, rules and the terms of their applicable Benefit Plans providing these services at a cost most advantageous to the Agencies and its Subscribers. |  |  |  |
| 4 | To review and advise the Agencies on the Plan designs set forth by the Agency (Exhibit I). The Selected Respondent will be responsible for advising the Agencies of all operational changes or pending legislative changes that may affect coverage provided under the Services during the term of the Agreement. |  |  |  |
| 5 | To provide any information that is necessary for the effective provision of the Services, including legal and administrative advice and assistance as needed and notices of changes in law that might affect the operations of the Plan and services provided under the Agreements. No Respondent is expected to provide legal advice to the Agencies, however, each Contractor must inform the Agencies promptly of any change in law, whether proposed or enacted, that would affect the operations, financing, Plan terms or administration of the benefit Plans. For insured products: to provide any required Certificates of Coverage and a Master Policy. For self-insured products, to provide any assistance required to revise the existing Plan documents. For all products, prior to implementation of the HMO services, the Contractor must provide documentation to the Agency to establish that it has correctly coded or initiated any claim or other system requirements to insure conformity with the benefit Plans included herein. |  |  |  |
| 6 | To provide insurance (if applicable) covering all operations of the prescription drug pharmacy network or prescription drug mail order program Services and/or its Subcontractors at no cost to the Agencies as set forth in Exhibit IV. |  |  |  |
| 7 | To address MBE/WBE (Minority Business Enterprise / Women Business Enterprise) goals and requirements of each Agency as set forth in Exhibit V. |  |  |  |
| 8 | To fully complete the ownership disclosure forms as required by the Agencies per Exhibit VI. |  |  |  |
| 9 | Reserved |  |  |  |
| 10 | To negotiate terms and conditions of an Agreement(s) with the Agencies on a timely basis. |  |  |  |
| 11 | To provide proposals for an Agreement term of at least 3 (three) years from the date of award. |  |  |  |
| 12 | To provide that the Agencies may renew the Agreement for up to 2 (two) additional 1 year periods. |  |  |  |
| 13 | In the event Respondent’s organization is currently providing Services to an Agency and is not selected to provide those Services to that Agency pursuant to this RFP, the Respondent agrees to cooperate fully with any vendor selected to replace the Respondent and take all actions necessary to smoothly transfer this function in the event that another vendor is selected to provide these Services to such Agencies following the expiration or termination of that other Agreement. The Respondent agrees that there shall be no additional costs associated with the termination of services and transfer of functions to another vendor. |  |  |  |
| 14 | To provide performance guarantees for a successful transition for January 1, 2016 or whenever the initial term of the Agreements with the Agencies commence. These performance guarantees must be financial in nature. |  |  |  |
| 15 | To provide performance guarantees for Services provided during the term of any Agreement. These performance guarantees must be financial in nature. |  |  |  |
| 16 | To provide all renewal information including costs, benefit levels, etc. to the Agencies at least 120 days prior to the expiration date of any Agreement period, in form and content acceptable to the Agencies. |  |  |  |
| 17 | Reserved |  |  |  |
| 18 | To agree that upon 30 days written notice of termination of Services, for insured services, Contractor will pay for any claims incurred prior to the termination in so far as Agency has paid premium for any period prior to the date of termination. For self-insured services, will agree to pay run-out claims at no additional administrative charge to the affected Agency, for a period of one year, provided the date of service is prior to the date of termination; the self-insured Agency will pay for run-out claims to the extent that the claim for service was otherwise covered and not subject to any applicable Physician Service fees at the Respondent’s Agreement rate for said services. |  |  |  |
| 19 | If applicable, and at the request of an Agency, the Contractor agrees to provide a specific aggregate “Stop Loss” coverage. |  |  |  |
| 20 | If required, to provide written representation and warranty that all Participating Providers, pharmacists, pharmacies, and Contractor’s own professional staff have met the Contractor's credentialing criteria and any licensing and/or certification requirements. |  |  |  |
| 21 | To retain all records directly or indirectly related to Contractor's performance of Services during the term of any Agreements and for a period of 7 years after termination or expiration of any Agreement or until all pending disputes are resolved. The Agencies have the right to review, abstract, audit and copy all records and accounts of the Contractor directly or indirectly related to any Agreements. |  |  |  |
| 22 | To provide, at no cost to the Agencies, training materials and on-site training sessions necessary for the implementation of the HMO Plan(s). |  |  |  |
| 23 | To participate in open-enrollment meetings on an as-requested basis. The Agencies will be reasonable in their requests for attendance at such meetings. However, the Respondent shall acknowledge that many of the Agencies have multiple work sites and that certain employees work non-standard hours in locations that span the City |  |  |  |
| 24 | If required, to attend Agency Health and Wellness Fairs at no additional cost. If requested by the Agency, shall provide a speaker(s) for Chicago Lives Healthy wellness program educational seminars at least quarterly at no cost to the Agencies. |  |  |  |
| 25 | To develop Subscriber communication brochures, pamphlets, and materials, subject to the Agencies' approval, which the Agencies consider necessary in order to communicate the Services. The development, production and distribution of materials must be at no cost to the Agencies. |  |  |  |
| 26 | To offer appropriate web-based applications for Subscribers including Plan information, eligibility information, identification card requests, cost comparison tools (if appropriate), key contacts, and other information that encourages the employee to maximize the value of their benefit plan, including provider network information. |  |  |  |
| 27 | To undertake all other necessary tasks to properly administer the Services for the Subscribers, including but not limited to, determining Subscriber eligibility for Services in accordance with the Agencies provided eligibility information at the point of service; sending communication materials on an as needed basis; (sending ID cards if applicable) responding to telephone and written or electronically submitted inquiries; appeals instructing/directing Subscribers/employees as to the appropriate and cost effective use of the HMO’s Benefits and Services. |  |  |  |
| 28 | To provide continuation coverage to employees who are on inactive status due to medical leave of absence, suspension, Worker’s Compensation, pension disability, or a temporary lay-off, in accordance with the Agency’s continuation of coverage programs. |  |  |  |
| 29 | If proposing an insured arrangement to provide a conversion option for employees who have exhausted COBRA (PHSA) coverage eligibility for Agencies which have conversion provisions for their self-funded PPO programs. |  |  |  |
| 30 | If proposing an insured arrangement, to provide the Services in the event that an employee has a potential work related injury or illness, the Plan may not deny any necessary dental services while a determination by the Agency is pending. In the case of self-insured proposals, to provide services in accordance with the policy of that Agency regarding potential work related injury or illness. |  |  |  |
| 31 | To accurately administer the Plans’ provisions so that claims are paid correctly and within the time frames provided for in the performance guarantee provisions established by each Agency. Accurate administration shall specifically include the correct application of fee schedules including reasonable and customary fees (if applicable); co-payments and/or co-insurance; coordination of benefits provisions consistent with NAIC standards; robust audit programs; and fraud and abuse programs to identify aberrant behavior on the part of providers including up-coding, unbundling, and inappropriate use of dental technology, materials, and supplies. |  |  |  |
| 32 | To provide a transition of care program for those persons who are in active treatment for significant disease or illness at the time of transition from the current vendor to the new Agreement. The transition of care program must address funding and length of treatment, especially if the treating providers are not in the network of the new Contractor. It is the intention of the Agencies that its Subscribers would be at no greater financial risk during and after such transition than they would have been had the current vendor continued to provide service. |  |  |  |
| 33 | To monitor the network of providers at least annually, to ensure Subscribers have appropriate access to all necessary medical services. If any deficiency in the applicable provider network is identified, the Contractor must agree to recruit sufficient providers of appropriate specialties into its network within three (3) months of the date the shortage is identified. |  |  |  |
| 34 | To work cooperatively and in good faith with the Agencies in order to assure that all Services are rendered in a prompt and accurate manner to all Subscribers and to meet with Agencies' representatives whenever necessary to promptly resolve any problems that occur. Be advised that the Agencies are a party to one or more collective bargaining agreements and as such, they may not change the terms of its benefit programs during a particular collective bargaining contract period unless such change is required by law or a court order. The Respondent shall specifically acknowledge that it understands the limits of the collective bargaining process and that in offering to provide services, it will not demand or otherwise attempt to change any benefit plan provision in effect at the time of award. Further, the Respondent shall acknowledge that it prepared its pricing proposal with full knowledge of this requirement. Proposer shall also acknowledge that it understands that if a benefit term is changed during the collective bargaining process, as Contractor, it will do what is required to effect any such change(s) without additional cost to the Agencies. |  |  |  |
| 35 | To provide required notifications to Subscribers in a timely manner. |  |  |  |
| 36 | To perform any and all administrative functions necessary to ensure financial control and accuracy. If any Agency determines that Services have been provided to an individual or individuals ineligible for Services, or that a Service has been provided which is excluded from coverage, the Contractor must reimburse the Agency for claims paid in error whether or not the Contractor has recovered such reimbursements from the claimant. |  |  |  |
| 37 | To use standardized data file formats and data transmission methods as may be required for the administration of the Services, subject to the Agencies' approval. |  |  |  |
| 38 | To provide Subscribers, their dependents and the Agencies with prompt, accurate, and courteous service. The Contractor must make accurate and timely determinations of eligibility for participation in the Services in accordance with eligibility information provided by the Agencies. Timely service specifically includes prompt issuance of identification cards, if required, and prompt recording (intake and processing) of overrides requested and/or immediate eligibility update requests. Additionally, each Agency reserves the right to provide the selected Proposer with its own custom generated set of unique identification numbers |  |  |  |
| 39 | To provide Services at a cost most advantageous to the Agencies' Subscribers. |  |  |  |
| 40 | Reserved |  |  |  |
| 41 | Reserved |  |  |  |
| 42 | Reserved |  |  |  |
| 43 | Reserved |  |  |  |
| 44 | Reserved |  |  |  |
| 45 | Reserved |  |  |  |
| 46 | Reserved |  |  |  |
| 47 | Reserved |  |  |  |
| 48 | Reserved |  |  |  |
| 49 | Reserved |  |  |  |
| 50 | Reserved |  |  |  |
| 51 | Reserved |  |  |  |
| 52 | Reserved |  |  |  |
| 53 | To maintain confidentiality of the Agencies' employee records and any other information deemed proprietary or confidential by the Agency or by law. Weekly, bi-monthly and monthly census information of Subscribers shall be provided by the Agencies to the Contractor. Census information must be used to determine eligibility for Services. While in the possession of the Contractor, census information remains the property of the corresponding Agency and must be returned upon termination of the Agreement with the Agency or upon request by the Agency. While in use by the Contractor, the confidentiality of these records must be maintained in accordance with all applicable laws and regulations, Agreement terms and conditions. This confidential information must not be used by the selected Respondent(s) for purposes other than the allowances specified in any Contract between the Agency and the selected Respondent(s). |  |  |  |
| 54 | To permit periodic audits of the Services. |  |  |  |
| 55 | To confirm audit rights are granted to validate adherence during the course of the contract. |  |  |  |
| 56 | To promptly rectify errors and resolve disputes in a manner satisfactory to the affected Agency. |  |  |  |
| 57 | To provide the Agencies with on-site customer service representatives to meet with the Agencies' employees when required; generally during the annual open enrollment periods for employee benefits. |  |  |  |
| 58 | To provide emergency contact information for key managers responsible for the Agencies' account. Such key managers must include both operational and account management staff that is of sufficient authority within the organization capable of resolving emergency situations. |  |  |  |
| 59 | To provide the Agencies with periodic billing, no less frequently than monthly, for the Services provided during the billing period. Subject to applicable law on patient confidentiality, invoices must indicate the following information at a minimum: a. Group number  b. Enrollee Unique Identification number  c. Enrollee name  d. Patient name & relationship to employee |  |  |  |
| 60 | To participate in a data exchange with medical plan administrators for purposes of Plan analysis to the extent permitted by law if directed by the Agencies. |  |  |  |
| 61 | To provide management information reports as requested by the Agencies. (See Exhibit XVII Agencies' Interrogatives, under Monitoring and Reporting, listing minimum reporting criteria.) The Agencies reserve the right to make changes in the content and frequency of reporting requirements. The Respondent(s) must provide reports as requested to assist the Agencies in their collective bargaining activities. |  |  |  |
| 62 | For prescription drug programs, if applicable, to confirm that savings from clinical programs are not counted towards discount calculations. |  |  |  |
| 63 | To contract with a broad network of generalist and specialist medical providers in sufficient quantities and of sufficient professional expertise to ensure that all Subscribers may obtain necessary medical services within a reasonable proximity to their residences. For these purposes, generalist physicians must be readily available within five (5) miles of the residence zip code of eligible members and their families; specialist physicians must be readily available within ten (10) miles. |  |  |  |
| 64 | To ensure that all network providers are insured, licensed, and meet all criteria established in Contractor's credentialing process; and to review credentialing requirements in accordance with Contractor's credentialing process. |  |  |  |
| 65 | To allow Subscribers to select a Primary Care Physician (PCP) who will the Subscriber's primary doctor from whom medical care services shall be managed through the healthcare system. |  |  |  |
| 66 | To arrange for the provision of emergency medical services within the service area during hours that the PCP is not available. |  |  |  |
| 67 | To arrange for the provision of emergency medical services for Subscribers who are traveling outside of the Contractor's service area. |  |  |  |
| 68 | To arrange for the provision of medical services for Subscribers who are temporarily domiciled outside of the Contractor's services area (for example, students who are temporarily outside of the Chicago area). |  |  |  |
| 69 | To design, implement and operate a program of quality assurance directed to medical providers to insure that Subscribers receive necessary medical services from quality healthcare providers including preventive services and routine medical services designed to limit or mitigate the effects of chronic disease. |  |  |  |
| 70 | To ensure that Subscribers receive necessary specialty medical services from high quality providers. |  |  |  |
| 71 | To insure that members have access to any required appeal processes for denied medical care, equipment or supplies. |  |  |  |
| 72 | To ensure that Subscribers have a process by which a request to go out of network for care can be fairly considered by appropriately credentialed medical professionals. |  |  |  |
| 73 | To ensure that Subscribers are informed about their options for treatment whether or not such treatments are available from their PCP or PCP related parties. |  |  |  |
| 74 | To creatively manage the provision of services such that the Agency's goals for this program are met. |  |  |  |
| 75 | To operate a fraud and abuse program and report to the Agencies about its successes. |  |  |  |
| 76 | To maintain web accessible member services to inform members about how best to use their benefit coverage and to encourage health and well-being. To make alternative services available for people with disabilities, as required by law. |  |  |  |
| 77 | To not disclose member information for any purpose not agreed to in writing by an Agency and/or Subscriber. |  |  |  |
| 78 | To allow a self-funded Agency to elect to outsource subrogation and third-party recovery services. |  |  |  |
| 79 | To allow an Agency to remove any provider from the network that is offered to its Subscribers. |  |  |  |
| 80 | To allow an Agency to carve-out prescription drug services to a PBM of its choosing. |  |  |  |
| end |  |  |  |  |

EXHIBIT XVIII - A

**CITY OF CHICAGO ONLY AGENCY**

**GOALS AND RESPONDENT’S OFFER FOR PRESCRIPTION DRUGS**

| **City of Chicago Goal #** | **Respondent's Offer to City of Chicago Prescription Drug Plan** | **Check √ if Shall Provide** | **Check √ if Shall Not Provide** | **Comment** |
| --- | --- | --- | --- | --- |
| 1 | To provide eligible Subscribers of the Agencies with prescription drug mail order program Services, in accordance with the terms of the City of Chicago's Benefit Plans. |  |  |  |
| 2 | To provide a secure hosted site from where a monthly report of prescriptions filled with data sufficient to allow analysis and audit. If the Agencies determine that the Services have been provided to an individual or individuals ineligible for benefits or that a prescription has been filled for a drug or a medical supply item that is excluded from coverage, the selected Respondent(s) must reimburse the Agency for benefits paid in error. |  |  |  |
| 3 | If directed by the Agencies, to encourage the filling of maintenance drugs through the prescription drug mail order program and to inform Subscribers of the advantages of refilling existing maintenance drug prescriptions through the prescription drug mail order program. If an Agency’s plan of benefits requires the use of mail order drug services, to correctly administer the requirement in accordance with its terms. |  |  |  |
| 4 | To maintain a cumulative record of the medications and medical supplies prescribed for each Subscriber. The Contractor must monitor drug interactions for Subscribers and, if a potential drug interaction might occur, Contractor must immediately contact the prescribing physician and advise of the potential interaction and seek further direction concerning use of the prescription. |  |  |  |
| 5 | To undertake all other necessary tasks to properly administer the prescription drug pharmacy network Services, the prescription drug mail order program Services or the integrated program as required by the Agencies. |  |  |  |
| 6 | To confirm that usual and customary (U&C) prescriptions are excluded from discount calculations. |  |  |  |
| 7 | To confirm that Subscribers are charged the lesser of: (a) the negotiated drug cost/discount plus dispensing fee, or (b) the pharmacy’s submitted usual and customary (U&C) amount, or (c) the Subscriber's co-pay. |  |  |  |
| 8 | To provide telephone and text messaging service about prescription Services for all Subscribers, 24 hours per day, 7 days per week. |  |  |  |
| 9 | To provide a sufficient number of pharmacies in close proximity to the residences of covered Subscribers that are open and available to dispense medications from 9:00 a.m. to 10:00 p.m. 7 days per week. The Agencies reserve the right to determine sufficiency of access. |  |  |  |
| 10 | To provide a sufficient number of pharmacies within 10 miles of the residences of covered Subscribers, that are open and available to dispense medications 24 hours a day, 7 days per week including holidays. The Agencies reserve the right to determine sufficiency of access. |  |  |  |
| 11 | To pay paper claims submitted for pharmaceutical drugs obtained outside the pharmacy drug network program. Claims must be submitted using Respondent’s standard claim form. |  |  |  |
| 12 | To negotiate with pharmacy companies and drug manufacturers to ensure that the expected total cost to the Agencies and expected fees for Services are as low as possible. Consistent with the volume of prescriptions purchased by the account, the Contractor must vigorously advise the Agencies as to the continued competitiveness of the price it is paying for drugs and Services. |  |  |  |
| 13 | To conduct drug utilization reviews, retrospectively and prospectively. |  |  |  |
| end |  |  |  |  |

EXHIBIT XIX – A

**CITY OF CHICAGO**

**DIRECT PAY RATES**

<< attached by reference >>

EXHIBIT XIX– B

**CHICAGO PARK DISTRICT**

**DIRECT PAY RATES**

<< attached by reference >>

**EXHIBIT XIX –– C**

**CHICAGO PUBLIC SCHOOLS**

**DIRECT PAY RATES**

<< attached by reference >>

**ATTACHMENT 1**

**Non-Disclosure and Confidentiality Agreement**



**ATTACHMENT I**

**Non-Disclosure and Confidentiality Agreement Concerning Census and Claims Data CDs concerning the Request for Proposal (RFP) for:**

HEALTH MAINTENANCE ORGANIZATION (HMO) and/or EXCLUSIVE PROVIDER ORGANIZATION SERVICES (EPO) – INCLUDING PRESCRIPTION DRUG REQUIREMENTS FOR CITY OF CHICAGO ONLY

and as required for use bythe *City of Chicago*, the *Chicago Park District*, and the *Chicago Public Schools* (the “Agencies”)

Specification No. 131782

I, the below undersigned, by signing this ATTACHMENT I form, hereby agree to keep secure and confidential all information contained in the CD as provided to me and shall, to the best of my reasonable ability, ensure that all information contained in the CD is used solely in response to the above referenced RFP; and

I also agree, unless as may otherwise be required by law, to *not* make copies of or otherwise share or disclose any information contained in the CD to any person other than such persons participating in this RFP process and who has also signed an ATTACHMENT I form; and

I agree that any unauthorized dissemination of any information contained in the CD, or to knowingly use any information for actual or anticipated personal gain, or for the actual or anticipated personal gain of any other person, is a breach of ethical standards which may be cause for termination of the RFP process in part or in whole; therefore,

I pledge my cooperation with and agreement to fully complying with all matters of security and confidentiality as indicated above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company

1. If Contractor is a joint venture or other legal entity for which this signature format is inappropriate, please substitute an appropriate signature page with appropriate attestation and notarization.

   END OF SAMPLE [↑](#footnote-ref-2)