REQUEST FOR PROPOSALS FOR

Providing Medical, Prescription, Dental and Vision Benefit Plans

ISSUING OFFICE

Pennsylvania Turnpike Commission

Human Resources Department

RFP NUMBER

11-10380-3395

DATE OF ISSUANCE

November 23, 2011

REQUEST FOR PROPOSALS FOR

Providing Medical, Prescription, Dental and Vision Benefit Plans

TABLE OF CONTENTS

COPIES OF THE APPENDICES LISTED BELOW WILL BE PROVIDED BY WRITTEN REQUEST ONLY. SEND REQUESTS FOR APPENDICES TO RFP-Q@paturnpike.com WITH RFP 11-10380-3395 IN THE SUBJECT LINE. REQUEST MUST INCLUDE YOUR COMPANY NAME, CONTACT PERSON, AND EMAIL ADDRESS.

PART I

GENERAL INFORMATION FOR PROPOSERS

I-1. Purpose. This request for proposals (RFP) provides interested Proposers with sufficient information to enable them to prepare and submit proposals for consideration by the Pennsylvania Turnpike Commission (Commission) to satisfy a need for providing medical, prescription, dental and vision benefit plans and services.

I-2. Issuing Office. This RFP is issued for the Commission by the Human Resources Department.

I-3. Scope. This RFP contains instructions governing the proposals to be submitted and the material to be included therein; a description of the service to be provided; requirements which must be met to be eligible for consideration; general evaluation criteria; and other requirements to be met by each proposal.

I-4. Problem Statement. Provide health care benefits and services for the Commission within the guidelines explained in Part IV of this RFP.

I-5. Type of Contract. It is proposed that if a contract is entered into as a result of this RFP, it will be a fee for services contract based on the line of coverage. The Commission may in its sole discretion undertake negotiations with Proposers whose proposals as to price and other factors show them to be qualified, responsible, and capable of performing the work.

I-6. Rejection of Proposals. The Commission reserves the right to reject any and all proposals received as a result of this request, or to negotiate separately with competing Proposers.

I-7. Subcontracting. Any use of subcontractors by a Proposer must be identified in the proposal. During the contract period use of any subcontractors by the selected Proposer, which were not previously identified in the proposal, must be approved in advance in writing by the Commission.

I-8. Incurring Costs. The Commission is not liable for any costs the Proposer incurs in preparation and submission of its proposal, in participating in the RFP process or in anticipation of award of contract.

I-9. Questions and Answers. Written questions may be submitted to clarify any points in the RFP which may not have been clearly understood. Written questions should be submitted by email to RFP-Q@paturnpike.com with **RFP 11-10380-3395** in the Subject Line to be received no later than **Tuesday, December 6, 2011 at 12:00 p.m. local time.**. All questions and written answers will be posted to the website as an addendum to and become part of this RFP.

I-10. Addenda to the RFP. If it becomes necessary to revise any part of this RFP before the proposal response date, addenda will be posted to the Commission's website under the original RFP document. It is the responsibility of the Proposer to periodically check the website for any new information or addenda to the RFP.

The Commission may revise a published advertisement. If the Commission revises a published advertisement less than ten days before the RFP due date, the due date will be extended to maintain the

minimum ten-day advertisement duration if the revision alters the project scope or selection criteria. Firms are responsible to monitor advertisements/addenda to ensure the submitted proposal complies with any changes in the published advertisement.

I-11. Response. To be considered, proposals must be delivered to the Pennsylvania Turnpike Commission's Contracts Administration Department, Attention: Wanda Metzger, on or before **Tuesday, December 20, 2011 at 12:00 p.m. local time.** The Pennsylvania Turnpike Commission is located at 700 South Eisenhower Boulevard, Middletown, PA 17057 (Street address). Our mailing Address is P. O. Box 67676, Harrisburg, PA 17106.

Please note that use of U.S. Mail, FedEx, UPS, or other delivery method, does not guarantee delivery to this address by the above-listed time for submission. Proposers mailing proposals should allow sufficient delivery time to ensure timely receipt of their proposals. If the Commission office location to which proposals are to be delivered is closed on the proposal response date, due to inclement weather, natural disaster, or any other cause, the deadline for submission shall be automatically extended until the next Commission business day on which the office is open. Unless the Proposers are otherwise notified by the Commission, the time for submission of proposals shall remain the same.

I-12. Proposals. To be considered, Proposers should submit a complete response to this RFP, using the format provided in PART II. Each proposal should be submitted in eight (8) hard copies and two complete and exact copies of the technical proposal on CD-ROM in Microsoft Office or Microsoft Office-compatible format to the Contracts Administration Department. No other distribution of proposals will be made by the Proposer. Each proposal page should be numbered for ease of reference. Proposals must be signed by an official authorized to bind the Proposer to its provisions and include the Proposer's Federal Identification Number. For this RFP, the proposal must remain valid for at least **180** days. Moreover, the contents of the proposal of the selected Proposer will become contractual obligations if a contract is entered into.

Each and every Proposer submitting a proposal specifically waives any right to withdraw or modify it, except as hereinafter provided. Proposals may be withdrawn by written or telefax notice received at the Commission's address for proposal delivery prior to the exact hour and date specified for proposal receipt. However, if the Proposer chooses to attempt to provide such written notice by telefax transmission, the Commission shall not be responsible or liable for errors in telefax transmission. A proposal may also be withdrawn in person by a Proposer or its authorized representative, provided its identity is made known and it signs a receipt for the proposal, but only if the withdrawal is made prior to the exact hour and date set for proposal receipt. A proposal may only be modified by the submission of a new sealed proposal or submission of a sealed modification which complies with the requirements of this RFP.

I-13. Economy of Preparation. Proposals should be prepared simply and economically, providing a straightforward, concise description of the Proposer's ability to meet the requirements of the RFP.

I-14. Discussions for Clarification. Proposers who submit proposals may be required to make an oral or written clarification of their proposals to the Issuing Office to ensure thorough mutual understanding and Proposer responsiveness to the solicitation requirements. The Issuing Office will initiate requests for clarification.

I-15. Best and Final Offers. The Issuing Office reserves the right to conduct discussions with Proposers for the purpose of obtaining "best and final offers." To obtain best and final offers from Proposers, the Issuing Office may do one or more of the following: a) enter into pre-selection negotiations; b) schedule oral presentations; and c) request revised proposals. The Issuing Office will limit any discussions to responsible Proposers whose proposals the Issuing Office has determined to be reasonably susceptible of being selected for award.

I-16. Prime Proposer Responsibilities. The selected Proposer will be required to assume responsibility for all services offered in its proposal whether or not it produces them. Further, the Commission will consider the selected Proposer to be the sole point of contact with regard to contractual matters.

I-17. Proposal Contents. Proposals will be held in confidence and will not be revealed or discussed with competitors, unless disclosure is required to be made (i) under the provisions of any Commonwealth or United States statute or regulation; or (ii) by rule or order of any court of competent jurisdiction. All material submitted with the proposal becomes the property of the Pennsylvania Turnpike Commission and may be returned only at the Commission's option. Proposals submitted to the Commission may be reviewed and evaluated by any person other than competing Proposers at the discretion of the Commission. The Commission has the right to use any or all ideas presented in any proposal. Selection or rejection of the proposal does not affect this right.

In accordance with the Pennsylvania Right-to-Know Law (RTKL), 65 P.S. § 67.707 (Production of Certain Records), Proposers shall identify any and all portions of their Proposal that contains confidential proprietary information or is protected by a trade secret. Proposals shall include a written statement signed by a representative of the company/firm identifying the specific portion(s) of the Proposal that contains the trade secret or confidential proprietary information.

Proposers should note that "trade secrets" and "confidential proprietary information" are exempt from access under Section 708(b)(11) of the RTKL. Section 102 defines both "trade secrets" and "confidential proprietary information" as follows:

Confidential proprietary information: Commercial or financial information received by an agency: (1) which is privileged or confidential; **and** (2) the disclosure of which would cause substantial harm to the competitive position of the person that submitted the information.

Trade secret: Information, including a formula, drawing, pattern, compilation, including a customer list, program, device, method, technique or process that: (1) derives independent economic value, actual or potential, from not being generally known to and not being readily ascertainable by proper means by other persons who can obtain economic value from its disclosure or use; **and** (2) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy. The term includes data processing software by an agency under a licensing agreement prohibiting disclosure.

65 P.S. §67.102 (emphasis added).

The Office of Open Records has determined that a third party must establish a trade secret based upon factors established by the appellate courts, which include the following:

the extent to which the information is known outside of his business;
the extent to which the information is known by employees and others in the business;
the extent of measures taken to guard the secrecy of the information;

the value of the information to his business and to competitors;
the amount of effort or money expended in developing the information; and
the ease of difficulty with which the information could be properly acquired or duplicated by others.

See Crum v. Bridgestone/Firestone North Amer. Tire., 907 A.2d 578, 585 (Pa. Super. 2006).

The Office of Open Records also notes that with regard to "confidential proprietary information the standard is equally high and may only be established when the party asserting protection shows that the information at issue is either 'commercial' or 'financial' and is privileged or confidential, and the disclosure ***would*** cause substantial competitive harm." (emphasis in original).

For more information regarding the RTKL, visit the Office of Open Records' website at www.openrecords.state.pa.us.

I-18. Debriefing Conferences. Proposers whose proposals are not selected will be notified of the name of the selected Proposer and given the opportunity to be debriefed, at the Proposer's request. The Issuing Office will schedule the time and location of the debriefing. The Proposer will not be compared with other Proposers

I-19. News Releases. News releases pertaining to this project will not be made without prior Commission approval, and then only in coordination with the Issuing Office.

I-20. Commission Participation. Unless specifically noted in this section, Proposers must provide all services to complete the identified work.

I-21. Cost Submittal. The cost submittal shall be placed in a separately sealed envelope within the sealed proposal and kept separate from the technical submittal. **Failure to meet this requirement may result in disqualification of the proposal.**

I-22. Term of Contract. The term of the contract will commence on the Effective Date (July 1, 2012) and will end February 28, 2015, with two (2) one-year renewal options. The Commission shall fix the Effective Date after the contract has been fully executed by the Contractor and by the Commission and all approvals required by Commission contracting procedures have been obtained.

I-23. Proposer's Representations and Authorizations. Each Proposer by submitting its proposal understands, represents, and acknowledges that:

a. All information provided by, and representations made by, the Proposer in the proposal are material and important and will be relied upon by the Issuing Office in awarding the contract(s). Any misstatement, omission or misrepresentation shall be treated as fraudulent concealment from the Issuing Office of the true facts relating to the submission of this proposal. A misrepresentation shall be punishable under 18 Pa. C.S. 4904.

b. The price(s) and amount of this proposal have been arrived at independently and without consultation, communication or agreement with any other Proposer or potential Proposer.

c. Neither the price(s) nor the amount of the proposal, and neither the approximate price(s) nor the approximate amount of this proposal, have been disclosed to any other firm or person who is a Proposer or potential Proposer, and they will not be disclosed on or before the proposal submission deadline specified in the cover letter to this RFP.

d. No attempt has been made or will be made to induce any firm or person to refrain from submitting a proposal on this contract, or to submit a proposal higher than this proposal, or to submit any intentionally high or noncompetitive proposal or other form of complementary proposal.

e. The proposal is made in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary or other noncompetitive proposal.

f. To the best knowledge of the person signing the proposal for the Proposer, the Proposer, its affiliates, subsidiaries, officers, directors, and employees are not currently under investigation by any governmental agency and have not in the last four (4) years been convicted or found liable for any act prohibited by State or Federal law in any jurisdiction, involving conspiracy or collusion with respect to bidding or proposing on any public contract, except as disclosed by the Proposer in its proposal.

g. To the best of the knowledge of the person signing the proposal for the Proposer and except as otherwise disclosed by the Proposer in its proposal, the Proposer has no outstanding, delinquent obligations to the Commonwealth including, but not limited to, any state tax liability not being contested on appeal or other obligation of the Proposer that is owed to the Commonwealth.

h. The Proposer is not currently under suspension or debarment by the Commonwealth, or any other state, or the federal government, and if the Proposer cannot certify, then it shall submit along with the proposal a written explanation of why such certification cannot be made.

i. The Proposer has not, under separate contract with the Issuing Office, made any recommendations to the Issuing Office concerning the need for the services described in the proposal or the specifications for the services described in the proposal.

j. Each Proposer, by submitting its proposal, authorizes all Commonwealth agencies to release to the Commission information related to liabilities to the Commonwealth including, but not limited to, taxes, unemployment compensation, and workers' compensation liabilities.

PART II

INFORMATION REQUIRED FROM PROPOSERS

Proposals must be submitted in the format, including heading descriptions, outlined below. To be considered, the proposal must respond to all requirements in this part of the RFP. Any other information thought to be relevant, but not applicable to the enumerated categories, should be provided as an appendix to the proposal. Each proposal shall consist of two (2) separately sealed submittals. The submittals are as follows: (i) Technical Submittal, in response to Part II-1 through II-7 hereof; (ii) Cost Submittal, in response to Part II-8 hereof.

The Commission reserves the right to request additional information which, in the Commission's opinion, is necessary to assure that the Proposer's competence, number of qualified employees, business organization, and financial resources are adequate to perform according to the RFP.

The Commission may make such investigations as deemed necessary to determine the ability of the Proposer to perform the work, and the Proposer shall furnish to the Issuing Office all such information and data for this purpose as requested by the Commission. The Commission reserves the right to reject any proposal if the evidence submitted by, or investigation of, such Proposer fails to satisfy the Commission that such Proposer is properly qualified to carry out the obligations of the agreement and to complete the work specified.

II-1. Statement of the Problem. State in succinct terms your understanding of the problem presented or the service required by this RFP.

II-2. Management Summary. Include a narrative description of the proposed effort and a list of the items to be delivered or services to be provided.

II-3. Work Plan. Describe in narrative form your technical plan for accomplishing the work. Use the task descriptions in Part IV of this RFP as your reference point. Modifications of the task descriptions are permitted; however, reasons for changes should be fully explained. Indicate the number of personhours allocated to each task.

II-4. Prior Experience. Include experience in administration of benefit programs and funding arrangements. Experience shown should be work done by individuals who will be assigned to this project as well as that of your company. Studies or projects referred to should be identified and the name of the customer shown, including the name, address, and telephone number of the responsible official of the customer, company, or agency who may be contacted.

II-5. Personnel. Include the number, and names where practicable, of executive and professional personnel, analysts, auditors, researchers, programmers, consultants, etc., who will be engaged in the work. Show where these personnel will be physically located during the time they are engaged in the work. Include through a resume or similar document education and experience in administration of benefit programs and funding arrangements. Indicate the responsibilities each will have in this project and how long each has been with your company. Identify subcontractors you intend to use and the services they will perform.

II-6. Training. If appropriate, indicate recommended training of Commission personnel. Include the personnel to be trained, the number to be trained, duration of the program, place of training, curricula, training materials to be used, number and frequency of sessions, and number and level of instructors.

II-7. Commitment to Diversity. It is a goal of the Commission to utilize qualified firms that have a demonstrated history of hiring, training, developing, promoting and retaining minorities and women and to encourage participation by qualified certified minority and woman-owned (MBE/WBE) firms, if available. The Commission recognizes the following minority and woman-owned business certifications for this RFQ. The Commission reserves the right to amend this list and maintains sole decision-making authority on the acceptance of certifying agencies and designations.

PA Unified Certification Program - www.paucp.com
PA Department of General Services - www.dgs.state.pa.us
National Minority Supplier Development Council - www.nmsdcus.org
Women Business Enterprise National Council - www.wbenc.org
U.S. Small Business Administration small disadvantaged businesses or 8(a) small disadvantaged business concerns

A. Diversity Questionnaire. A diversity questionnaire is required to be completed by the Respondent to ensure a commitment to equal opportunity and affirmative action **(see Attachment A.)**.

B. Purpose of Diversity Questionnaire. The information requested in the Diversity Questionnaire is designed to elicit appropriate information about the Respondent in order to verify that its work environment demonstrates a strong commitment to diversity.

C. Types of Information Requested. The required information includes information on the demographics of the Respondent's upper level management and corporate commitment to diversity and equal opportunity initiatives.

D. Certification Requirement. A person authorized to bind the Respondent contractually must submit with the firm's statement of qualifications a certification outlining the Respondent's continued commitment to its diversity initiatives.

II-8. Cost Submittal. The information requested in this section shall constitute your cost submittal. **The Cost Submittal shall be placed in a separate sealed envelope within the sealed proposal, separate from the technical submittal.**

Proposers should **not** include any assumptions in their cost submittals. If the proposer includes assumptions in its cost submittal, the proposal may be rejected. Proposers should direct in writing to the Issuing Office pursuant to Part I-9 of this RFP any questions about whether a cost or other component is included or applies. All proposers will then have the benefit of the Issuing Office's written answer so that all proposals are submitted on the same basis.

A. Actual Cost
For self-insured plans: Please provide a specific breakdown of your administrative fees as proposed, for all subgroups in a per employee per month basis and as a percentage of claims.

For fully-insured plans: Please provide a specific breakdown of the monthly per employee per month premiums using a five-tier structure as well as a composite rate.

If a service listed below is not included in the administrative fees, or per employee per month basis listed above, please provide a breakout. Proposers must clearly identify any additional fees/costs including but not limited to, the following:

a. Network access
b. Utilization management
c. Case management
d. Hard copy directories
e. Employee/Retiree communication materials
f. Implementation
g. Special billing charges
h. On-line services
i. Reporting and any special custom reporting
j. Run-out and the length of time for the run-out
k. HIPAA certificates
l. Creditable Coverage Notices
m. Services other than what is listed above

B. Cost Questions

Please submit your response to the following:

a. If there is a broker/consultant with your proposal, please list the percentage or commission amounts the broker will receive if you are awarded the Commission's contract.
b. Please provide the expected maximum dollar value of the Performance Guarantees by category as outlined in your proposal.
c. Please quote on an experience-rated basis and provide details (actual rate calculation) on how initial rates were calculated including a breakout of anticipated claims expenses (i.e. pure premium) and non-claims expenses (i.e. retention). Explain simply (verbally and through numeric example) how the proposed rates were developed from current claims experience including levels of discounts, assumed network utilization, etc.
d. Please detail your experience rating methodology and provide an example of a renewal calculation assuming each of the following:
    i. Claims are 25% lower than expected
    ii. Claims are at the expected level
    iii. Claims are 25% higher than expected
e. List the earliest a renewal and COBRA rates can be provided and guaranteed.
f. List your average loss ratio (paid and incurred) for each product offered over the past three years.
g. Provide details on your "other party liability" functions including documentation of quantifiable savings.
h. Provide details on your subrogation functions including documentation of quantifiable savings.
i. Describe in detail how the credibility of the group's experience is determined.
j. Describe your current pooling level and how any applicable charge is calculated.
k. Describe the funding arrangements that you offer.
l. Under an ASO arrangement, when does the settlement process take place, assuming a 12/12 stop loss? Assuming a 12/15 stop loss?

m. Under an ASO arrangement, is an advance deposit, cash advance, or letter of credit required? If so, how is the initial amount determined? How is each subsequent year determined?
n. Are there any payment options available that would eliminate the need for an advance deposit, cash advance, or letter of credit (i.e., weekly billing)?
o. For medical and prescription only: The Commission is certified for participation in Early Retiree Reinsurance Program and will need quarterly claim reports from the medical and prescription vendor(s). Please list any costs associated with quarterly reporting for the Early Retiree Reinsurance Program.
p. <u>For prescription only:</u>
    i. Please confirm that the discounts that exceed the stated maximums listed in your proposal will be passed through to the Commission. Explain.
    ii. Please confirm that the AWP as proposed does not include repackaging discounts. Explain.
    iii. Please provide a breakdown of the total costs as proposed by applying all of the discounts, rebates, administrative fees, etc. to the subset of prescription claims data provided to you in APPENDIX B of the RFP. If expected rebates *are not reflected* in your report results, please list the rebates separately.
    iv. Please list all costs associated with Medicare Part D subsidy reporting.

Any costs not provided in the cost proposal will be assumed as no charge to the Commission.

The selected Proposer shall only perform work on this contract after the Effective Date is affixed and the fully-executed contract sent to the selected Proposer. The Commission shall issue a written Notice to Proceed to the selected Proposer authorizing the work to begin on a date which is on or after the Effective Date. The selected Proposer shall not start the performance of any work prior to the date set forth in the Notice of Proceed and the Commission shall not be liable to pay the selected Proposer for any service or work performed or expenses incurred before the date set forth in the Notice to Proceed. No Commission employee has the authority to verbally direct the commencement of any work under this Contract.

PART III

CRITERIA FOR SELECTION

III-1. Mandatory Responsiveness Requirements. To be eligible for selection, a proposal should be (a) timely received from a Proposer; (b) properly signed by the Proposer; and (c) formatted such that all cost data is kept separate from and not included in the Technical Submittal.

III-2. Proposal Evaluation. Proposals will be reviewed, evaluated, and rated by a Technical Evaluation Team of qualified personnel. The Technical Evaluation Team will present the evaluations to the Professional Services Procurement Committee (PSPC). The PSPC will recommend for selection those firms that most closely meet the requirements of the RFP and satisfy Commission needs. Award will only be made to a Proposer determined to be responsive and responsible in accordance with Commonwealth Management Directive 215.9, Contractor Responsibility Program.

III-3. Evaluation Criteria. The following criteria will be used, in order of relative importance from the highest to the lowest, in evaluating each proposal:

a. Understanding the Problem. This refers to the Proposer's understanding of the Commission needs that generated the RFP, of the Commission's objectives in asking for the services or undertaking the study, and of the nature and scope of the work involved.

b. Proposer Qualifications. This refers to the ability of the Proposer to meet the terms of the RFP, especially the time constraint and the quality, relevancy, and recency of studies and projects completed by the Proposer. This also includes the Proposer's financial ability to undertake a project of this size.

c. Personnel Qualifications. This refers to the competence of professional personnel who would be assigned to the job by the Proposer. Qualifications of professional personnel will be measured by experience and education, with particular reference to experience on studies/services similar to that described in the RFP. Particular emphasis is placed on the qualifications of the project manager.

d. Soundness of Approach. Emphasis here is on the techniques for collecting and analyzing data, sequence and relationships of major steps, and methods for managing the service/project. Of equal importance is whether the technical approach is completely responsive to all written specifications and requirements contained in the RFP and if it appears to meet Commission objectives.

e. Cost. While this area may be weighted heavily, it will not normally be the deciding factor in the selection process. The Commission reserves the right to select a proposal based upon all the factors listed above, and will not necessarily choose the firm offering the best price. The Commission will select the firm with the proposal that best meets its needs, at the sole discretion of the Commission.

f. Commitment to Diversity. The Respondent's demonstrated diversity and equal employment record, including: (i) recognition of the Respondent's equal employment opportunity and diversity policies, programs and initiatives; (ii) the diversity of the staff that will be substantially involved in work performed for the Commission and the firm's plan for utilizing minority and women staff in such work; (iii) the Respondent's status as a certified MBE/WBE; and (iv) the Respondent's plan for utilizing minority and women staff in partnering or joint venture arrangements proposed by the firm, if applicable.

PART IV

WORK STATEMENT

IV-1. Objectives.

a. **General.** The Commission is soliciting proposals from qualified vendors for a contract for a two years and eight months contract with 2 one-year renewable extensions for the administration of its health care programs and services.

b. **Specific.** The Commission is soliciting competitive proposals to reduce health care costs, provide high quality service, and to effectively manage and control claim information for the following benefit and insurance plans: medical, prescription, dental and vision. Go-live for these benefit plans would be July 1, 2012, but the benefit plan year will remain March 1, 2012 through February 29, 2013. Providers selected will receive service information from current vendors in order to administer remaining plan year services such as coverage limits.

IV-2. Nature and Scope of the Project.

a. **Background.** The Commission is an independent agency of the Commonwealth of Pennsylvania. As a government agency, the Commission is not governed by the rules, regulations, or legislative requirements of ERISA.

The PA Turnpike is a key transportation route within the state of Pennsylvania and a vital link in the network of the eastern United States. The Turnpike is 536 miles in length with 60 fare collection facilities, 20 service plazas and two welcome centers, 21 maintenance buildings, 8 police barracks and 5 tunnels (www.paturnpike.com).

As of October 3, 2011, there were 459 non-union and 1,687 union (covered by the Teamsters Union) employees of the Commission who work in over 110 locations including three administrative offices: the Central Administration Office in Middletown, PA, the Eastern Regional Office in King of Prussia, PA and the Western Regional Office in New Stanton, PA. There are also almost 1,000 retirees of the Commission.

b. **Scope.** The Commission provides medical and prescription benefit plans to approximately 3,000 employees and retirees, and additionally to their eligible family members. The Commission offers 3 different medical plans; a PPO plan for active employees and most retirees under the age of 65, a traditional ClassicBlue indemnity plan for a small segment of retirees under age 65, and a signature 65 Medicare wrap-a-round plan for retirees age 65 and over. The Commission offers 3 different prescription plans; a plan for active employees, a plan for retirees under the age of 65, and a plan for retirees age 65 and over. The medical and prescription plans are separated into union and non-union groups. Additionally, the Commission offers one dental plan and one vision plan, both of which are available only to non-union employees and retirees.

Additionally, the Commission offers two Medicare Advantage plans to retirees; however, they will not be included in this RFP. The administration of COBRA continuation coverage is currently outsourced and will also not be included in this RFP. An RFP for stop loss insurance will be out for bid in October/November, but will be handled separately from this RFP since it has a go-live date of March 1, 2012 rather than July 1, 2012.

The Commission will be utilizing the services of a benefits consultant for the review and analysis of proposals received in response to this RFP. The benefits consultant will not have been formally selected prior to the due date for this RFP. In 2002, the Commission utilized Marsh Inc. to assist with choosing benefit providers. In 2007, Innovative Risk Solutions was used to assist with choosing benefit providers.

IV-3. Requirements. You must be able to complete the tasks exactly as specified in Part IV-4 below. Your proposal should include a performance guarantee covering the quality, timeliness and accuracy of your processes for the contracted services.

IV-4. Tasks. *Please be sure to carefully review this information prior to composing your response.*

Plan Information

Current benefit plans/carriers have been in place since March 1, 2008, with agreements ending June 30, 2012. All benefit options listed below are self-insured, and are provided on a calendar year basis. Current administrative fees, policies and agreements will not be provided. Employees and under age 65 retirees do not currently pay any premium contributions for the plans. Union retirees pay a portion of their over age 65 coverage. Benefit plans included in this RFP include the following:

- Medical – through Highmark Blue Shield
  - Applies to non-union and union employees, as well as non-union and union retirees.
  - Three plans: PPO Plan, traditional ClassicBlue indemnity plan, and Signature 65 Medicare wrap-a-round plan. There is not currently a wellness program in place.
  - Active employees, and most retirees under age 65 are on the PPO plan; a small segment of retirees under age 65 are on the ClassicBlue indemnity plan; and the majority of retirees age 65 or over are on the Signature 65 Medicare wrap-a-round plan.
  - Non-union employees are eligible on the first of the month following their hire date. Union employees are eligible on the first of the month following 90 days employment.

- Prescription Drug – through Aetna Life Insurance Company
  - Applies to non-union and union employees, as well as non-union and union retirees.
  - Three plans: An active employee plan, a retiree plan for retirees under age 65, and a retiree plan for retirees age 65 or over.
  - Non-union employees are eligible on the first of the month following their hire date. Union employees are eligible on the first of the month following 90 days employment.

- Dental – through United Concordia Companies, Inc.
  - Applies to non-union employees and retirees. Union employees are covered through the Teamsters Health and Welfare Fund, and are not included in this portion of the RFP.
  - One plan for both active employees and retirees, regardless of age.

- Non-union employees are eligible the first of the month following hire date.

- Vision – through Highmark Blue Shield, with Davis Vision
  - Applies to non-union employees and retirees. Union employees are covered through the Teamsters Health and Welfare Fund, and are not included in this portion of the RFP.
  - One plan for both active employees and retirees, regardless of age.
  - Non-union employees are eligible the first of the month following hire date.

The effective date of the contract will be July 1, 2012, but the benefit plan year will remain March 1, 2012 – February 29, 2013.

The Commission's health plans are considered to be "grandfathered health plans" under the Patient Protection and Affordability Care Act (PPACA), which exempts the Commission from many, but not all, of the coverage mandates under PPACA.

The Commission is approved for participation in PPACA's Early Retiree Reinsurance Program. The Commission requests quarterly reimbursements of eligible medical and prescription expenses for retirees age 55 and older who are not yet eligible for Medicare, and their eligible spouses and dependents.

Detailed plan information is included in in the appendices. Please be sure to match the benefits presented. In the case of the union plans, the benefits must be matched precisely to the current plans. If you are unable to match any provision of the union plans, please clearly state any variations, and highlight the variances. The Commission is willing to entertain benefit enhancements on all plans and you are invited to present alternatives; but bear in mind that the current plan must also be included.

⇒ Please quote all programs using the assumption that you may not be awarded all of the programs and may in fact be one of many carriers providing services to the Commission.

If your proposal includes more than one benefit coverage (i.e. includes both medical and prescription, or medical and vision, etc.), please clearly identify any changes or variances that you would have to your proposal if you are awarded only one of the benefit coverage's presented.

Additionally, please clearly identify any changes or variances that you would have to your proposal if you are not the only vendor awarded the same line of benefit coverage (i.e. two vendors for the same line of coverage may be selected due to coverage areas, network, etc.).

ELIGIBILITY

Selected benefit plans and contracts will cover eligible employees/retirees of the Commission, as well as eligible spouse/dependents of employees/retirees. Eligibility is determined by the Commission and simply passed along to the carriers for enrollment/disenrollment purposes. Dependents that meet the following criteria will be eligible for coverage under the benefit plans:

a. A contract holder's spouse.

b. Children under 26 years of age*, including:
   1. Stepchildren.
   2. Newborn children.

3. Legally adopted children of the contract holder or the spouse. An adopted child is considered acquired on the date when the member takes active or constructive possession of the child.
4. Children legally placed for adoption.
5. Any child for whom the member is a legal guardian.

*Children 19-26 years of age are not eligible under this program if they are eligible to enroll as a covered employee or spouse under an eligible employer-sponsored health plan other than through a parent.

c. Unmarried children to any age if the child is incapable of self-support due to mental retardation, physical handicap, mental illness or developmental disability, where the disability began before age 19. The disability must be medically certified by a physician through the medical carrier. The plan may require proof of such member's disability from time to time.

d. Grandchildren of an employee/retiree are excluded as eligible dependents except where:
   1. Employee/Retiree has legally adopted the grandchild;
   2. Employee/Retiree has obtained legal custody of the grandchild in accordance with a court order signed by a judge; or
   3. Employee/Retiree is responsible for the sole support of the grandchild as a result of the death of his/her parents.

e. A newborn child of a member will be considered a dependent under this program for 31 days immediately following birth. If the member wishes to continue coverage for the newborn beyond that date, the infant must be enrolled for coverage.

Financing

All plans should be quoted on a fully insured basis and on a self-insured basis. For self-insured proposals, please outline the different financial methods you can offer to accomplish a self-insured plan.

Although the contract begins July 1, 2012, all future benefit plan renewals are to be effective March 1st, and should include a minimum 120-day notice of annual renewal.

Assume that the current administrator will handle any claims run out if necessary.

Please indicate your ability to provide multiple year administrative fee guarantees.

All plans that include deductible and out of pocket maximum provisions should be quoted under the assumption that these amounts will be credited from the current plans. Dollars accumulated toward an individual's lifetime maximum are to be carried over as well. Please confirm this in writing with your submission.

Timeline*

Item Description	Due Date
RFP available for issuance	**November 23, 2011**
Questions due from vendors	**December 6, 2011**
Proposals due from vendors	**December 20, 2011**
Vendor presentations (finalists only)	**Late January/Early February 2012**
Provider award/approval	**March/April 2012**
Implementation	**April – June 2012**
Effective date of contracts	**July 1, 2012**

***Any changes to the above timeline prior will be at the discretion of the Commission.**

Proposal Requirements

The following information is prepared for your use. The Commission expects these conditions to be reviewed and signed by an executive officer of your company indicating your acceptance at the end of this exhibit (D. Acceptance of Requirements). Failure to properly execute and return this document with your proposal will affect your standing as a finalist.

A. Administrative Requirements

1) No participant will lose benefits as a result of a change in carrier (no loss/no gain). Evidence of Insurability will not be required of any individual on this plan.

2) There is no actively at work requirement or pre-existing condition limitation.

3) You will act in accordance with the documents and instruments governing the Commission's Plan and comply with all applicable state and federal laws and regulations, including but not limited to:

   - Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")
   - Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including the nondiscrimination, special enrollment, coverage certification, and other HIPAA requirements;
   - Mental Health Parity Act of 1996;
   - Newborns' and Mothers' Health Protection Act of 1996; and the
   - Women's Health and Cancer Rights Act of 1998.

   As part of these obligations, you will provide continuation of coverage to qualified beneficiaries as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), track and provide former participants with HIPAA prior coverage certifications. You will store, transmit, and communicate protected health information and protect the privacy of individually-identifiable health data as required under applicable federal and state law.

4) You will demonstrate adoption of arrangements to protect the Commission and its affiliates and plan participants from incurring liability for payment of any fees which are your legal obligation,

including but not limited to (i) sufficient insolvency and liability insurance, (ii) a contractual arrangement with medical providers affiliated with you that prohibits such providers from holding any participant liable for payment of any fees which are your obligation, and (iii) other protection from liability for participants as provided by applicable state or federal laws.

5) You will act promptly in response to complaints made by participants and beneficiaries, maintain written records of such complaints, and make grievance appeal procedures available where applicable when addressing such complaints. The Commission shall have the right to inspect such written records during normal business hours upon notice to you.

6) Vendors must be licensed in Pennsylvania to provide the services proposed. Products regulated by the State Insurance Department must be fully approved for delivery. Vendors must provide a copy of certificate of authority from the Pennsylvania Department of Insurance.

7) Vendors must be able to receive an interface in the HIPAA-compliant 834 interface format.

8) The cost of producing and mailing Evidence of Coverage (EOC) to employees must be included in your rates.

B. Financial Requirements

1) Initial rates are guaranteed for a minimum of 8 months, beginning July 1, 2012. Future rates will be guaranteed for a minimum of 12 months.

2) Rates provided (for fully insured products, or for COBRA rates for self-insured products) will be composite and five-tier rate structures.

3) Annual rate renewals must be provided by October 1 for March 1 rate changes.

4) Annual accounting reports must be delivered to the Commission within 120 days after the end of the policy period.

5) Premiums will not be adjusted at any time during the plan year unless the Commission requests and agrees to off-anniversary benefit changes.

6) The Commission will pay premium payments or administrative fees based upon Commission enrollment numbers each month.

C. Administrative Service Expectations and Performance Guarantee

The Commission expects your benefit or insurance plan to provide premium service in administering benefits to our employees. To help accomplish that goal, we expect the plan to guarantee that the following administrative functions will be performed in a consistent and timely manner.

1) Generally, new enrollments, changes and cancellations will be processed the next business day following receipt. Situations may arise where enrollment changes will need to be made immediately.

2) 99% of ID cards for ongoing enrollment will be accurate and mailed to the appropriate plan participants within 15 days of notification.

3) Claims reports, upon request, must be able to breakout Commission Management and Union benefits; show utilization by age/sex, employee/dependent status, and type of service; show enrollment info for specific time periods; and show benefit category by claim amount. Reports must comply with HIPAA regulations and cannot disclose Protected Health Information of employees unless exclusively requested by the Commission.

4) You must be able to support several group numbers and various types of benefits for both active and retired employees at no additional charge. The Commission has different group numbers for different groups of employees for budgeting purposes.

5) You must be able to produce a customized handbook, customized ID cards, electronic enrollment and delivery of handbooks no later than the date of plan implementation.

6) You must provide dedicated customer service representatives with a dedicated toll free telephone number to answer questions for both employees and the Human Resources department of the Commission.

7) Commission contracts must be in accordance with requirements of the Attorney General of the state of Pennsylvania and the Commission. Contracts should be signed by both parties prior to the effective date of the contract.

D. Acceptance of Requirements

Insurer or Plan Administrator agrees to the provisions of the specifications:

_____ Without exception

_____ With exceptions described below

Exceptions:

Insurer or Plan Administrator: _____

Location: _____

Officer's Signature: _____

Officer's Printed Name: _____

Title: _____

Date: _____

V. Questionnaire

A. GENERAL INFORMATION – ALL CARRIERS

Please respond to all items listed below. Follow the format provided below so your response to each item is distinguishable from other information. If an item does not apply to your line of business, so state. (For example, not all network questions listed below may apply to prescription.)

COMPANY BACKGROUND

a) Years in group benefit plan administration.
b) Products offered.
c) Area/Markets served (including counties).
d) Number of total groups.
e) Number of groups with over 3,000 lives covered.
f) Number of members covered.
g) Number of employees.
h) Any Subsidiaries and/or Affiliates.
i) Company financial information and ratings.
j) Future plans for group benefit plan administration (i.e. where you see your organization going in the next five years; network development, contracting approaches, other changes, etc.).
k) Explain what differentiates you from your competitor.

NETWORK

a) Describe your national network service area.
b) Describe how you recruit new providers and facilities.
c) Describe last three years turnover rate for providers and facilities.
d) Describe provider fee schedule methodology.
e) Please submit a comprehensive disruption analysis report illustrating any members whose current providers are not within your network.
f) Please provide an internet and telephone resource for network participation information.
g) For in-network providers, provide details on your provider-negotiated contracts (specify percentage (%) difference between negotiated amounts vs. charges). Provide the basis for your in-network reimbursement levels and your definition of "reasonable and customary" charge.
h) List any exceptions or restrictions.
i) Explain in detail how members residing outside of your service area would be covered and how their benefits will be administered.
j) Explain how a member would access your network while traveling; both in the United States and abroad.
k) Please explain how emergencies are paid for an out-of-network provider, and if there will be any balance bill to the participant.
l) Regarding an emergency service for an out-of-network provider, once the participant is stabilized, please explain the continuation of care process.

m) Explain how the employee and employer are notified of provider changes, network changes and coverage changes. Will the Commission be able to opt out of changes that violate union-negotiated benefits?
n) What are the financial arrangements if a provider terminates his or her contract with your organization in the middle of the course of treatment of a patient?
o) What are the financial arrangements if a patient loses coverage in the middle of a course of treatment?
p) Advise of your willingness and capability to develop networks in locations where you do not now have acceptable access. Under what conditions would you do so? What would be the time frame?
q) How do you assess member satisfaction in your networks? How often do conduct this assessment? To whom are the results made available? Please provide specifics on how this is tested, with current results.

CUSTOMER SERVICE

a) Include information regarding location, days, hours of operation.
b) Number of people handling the processing of claims.
c) Describe employee experience and training requirements.
d) Provide background on key personnel.
e) Provide statistical data with regard to:
    1. Time to answer
    2. Abandonment rate
    3. Customer satisfaction rate
f) Please outline the procedure an employee is to follow if satisfactory resolution is not received from your customer service staff.
g) Are you willing to provide a toll free dedicated customer service phone number to the employees of the Commission? To the Human Resources department for employer inquiries?
h) Who would be responsible for day-to-day service issues and problem resolution? Where is this individual located? Please provide a brief professional biography of the team leader responsible for daily issues regarding customer service, billing, claims and group related sales issues.

WEBSITE FEATURES

a) Describe your electronic capabilities with respect to electronic and/or online enrollment, maintenance of eligibility records and access to electronic reports.
b) Describe your <u>employee</u> internet capabilities with respect to online directories, access to claims, view/change enrollment data and ability to order ID cards, the ability to change physicians if applicable and other services available to members of the Commission.
c) Describe your <u>employer</u> internet capabilities with respect to online directories, access to claims, view/change enrollment data and ability to order ID cards, and other services available to Human Resources personnel of the Commission.

CLAIMS PROCESSING

a) Describe your system capabilities.

b) Describe the system edits, procedures, and internal and external audit processes used to ensure that only medically necessary claims, and valid claims based on plan provisions, are paid by the plan.
c) Are network, customer service notes and utilization management information integrated with claims system?
d) Describe your capabilities as they relate to the Administrative Simplification provisions of HIPAA. Are you capable of processing enrollment and record changes in accordance with HIPAA requirements?
e) Describe transition of care for patients currently under care.
f) Describe the appeals process if a member believes a denied claim should have been paid.
g) Describe your means for obtaining Coordination of Benefits (COB) info, and COB procedures for in-network and out-of-network claims. How do you determine COB savings for Medicare eligibles? For non-Medicare eligibles? How often is this information updated?
h) Provide statistical data relative to turnaround time and accuracy.
i) Advise if there will be any major system changes that could affect enrollment or claims in the next 12-24 months, and how you will ensure minimal disruption to the participant and the Commission.
j) Please provide performance guarantees (timeliness, accuracy, etc.) and indicate any costing specifics separately in Part II-8.

IMPLEMENTATION

a) Describe your experience with 834 interfacing.
b) Please provide a detailed implementation transition plan and timetable including but not limited to: plan setup and 834 interfacing.
c) Would you be willing to conduct a site visit and/or claims office visit for designated members of the Commission?
d) Confirm your ability to provide COBRA tiered rates for each group under the plan, even for self-insured plans.

MISCELLANEOUS

a) Describe your experience with the Systems, Applications and Products in Data Processing (SAP) system and confirm your ability to interface with SAP.
b) Please list the percentage of eligible employees that must be enrolled under your group plans. Does that change if more than one vendor for the same line of coverage is awarded a contract?
c) Please provide specific information regarding Performance Guarantees especially as they pertain to claims turnaround and customer service problem resolution. Are you willing to provide a Performance Guarantee for both timeliness and accuracy with respect to Account Management and Claims Payment? What is the level of risk you are willing to place on a Performance Guarantee?
d) Are you willing to provide a Performance Guarantee with respect to the timely issuance and accuracy of identification cards, employee benefits booklets and program contracts? What is the level of risk you are willing to place on a Performance Guarantee?
e) Please describe in detail any wellness programs that are available and how an employee would access these programs. Please include any additional costs if applicable.

f) Please provide details regarding value-added services such as wellness discounts, vision and dental benefits, and include any associated costs in Part II-8.
g) Advise on your willingness to attend Commission-sponsored open enrollment meetings or pre-retirement seminars.
h) Do you provide group level and member level newsletters or other publications? On what topics? Please provide samples.
i) Indicate your willingness to participate in health benefits fairs at multiple locations in-state, and discuss activities you can present such as blood pressure screening, body fat analysis etc.
j) Please describe your billing procedures. Is electronic billing available? Please describe your electronic billing capabilities including invoices, reports and payments. Is a detailed bill available each month?
k) Please describe in detail the reports that are available to the Commission. How much customization is available?

REFERENCES

a) Provide three references of current employer groups of similar size and scope. Include how long each has been a customer and the approximate number of employees.
b) Provide three references of former employer groups of similar size and scope. Include how long each was a customer and the approximate number of employees.

SAMPLE DOCUMENTS REQUESTED

a) Identification card
b) Billing statement (detailed and summary)
c) Explanation of benefits
d) Enrollment application
e) Provider directory for each network quoted
f) Sample of the reporting package included
g) Most recent annual report
h) HIPAA continuation certificate
i) Employee benefit booklets

B. MEDICAL CARRIERS ONLY

a) How many networks can you offer to the Commission? Please include information (if applicable) regarding each network including the following:
   i. Year network organized
   ii. Type (PPO, POS, Indemnity etc.)
   iii. Organization's relationship to network (i.e., owned, affiliated, etc.)
   iv. Current number of Hospitals, Ancillary facilities, PCP's, and Specialists under contract
   v. Number of the above that are JCAHO-accredited or board certified
   vi. Number of Hospitals, Ancillary facilities, PCP's, and Specialists in network in each of the past 3 years
   vii. Number of Hospitals, Ancillary facilities, PCP's, and Specialists in market area
   viii. Number of PCP's and Specialists with closed practices as of January 1, 2007
   ix. Hospital, PCP, and Specialist turnover numbers over the past 3 years (Network initiated and Provider initiated)
   x. Length of Contract (Hospital, Ancillary facilities, PCP, and Specialist)
   xi. Length of Termination Notice (Hospital, Ancillary facilities, PCP, and Specialist)
   xii. Percentage (%) of providers that participate in market area

b) Please provide a geo access report using the following standards: two Primary Care Physicians within an 8-mile radius; two Specialty Care providers within an 8-mile radius and one hospital within a 10-mile radius.

c) Explain in detail any current plans you have to reconfigure your networks to meet the needs of the Commission. Include detailed timelines and work plans.

d) Describe the process for certifying a disabled dependent.

e) Are you able to provide the Commission with reports of Medicare eligible? How often?

f) Describe the following programs/procedures that would be included in your proposal, and how a member would access these programs:
   i. Large case management (high dollar cases)
   ii. Case management
   iii. Disease management
   iv. New programs in development?

g) Explain the criteria used to determine an emergency claim vs. an urgent situation claim. How are they covered under the plan?

h) Describe how you will handle ongoing transition of care in the following situations where:
   i. An eligible member is receiving treatment on the effective date of coverage
   ii. Member is hospitalized
   iii. Member is receiving major ongoing treatment (not hospitalized) for an acute condition
   iv. Member is receiving major ongoing chronic care requiring specialized management
   v. Member is receiving non-acute ongoing care
   vi. Member is pregnant
   vii. Member is receiving ongoing treatment for outpatient mental health or substance abuse
   viii. Member is receiving ongoing treatment for any of the above conditions with a non-participating provider (continuity of care)

i) Describe your HIPAA Certification services and procedures.

C. PRESCRIPTION CARRIERS ONLY

a) Please describe your retail pharmacy network including the number of pharmacies in Pennsylvania, the number outside of Pennsylvania and the percentage of pharmacies that participate.
b) Please list the major pharmacy chains that participate in your network, and list any major pharmacy chains that do not participate in your network.
c) Is your network accessible to members traveling abroad?
d) List the location of the facility that will provide services for mail order prescriptions and the number of employees that are located at that facility.
e) Describe any quality assurance procedures that are currently in place to ensure all prescriptions are filled correctly and in a timely manner.
f) What is the average turnaround time for a new prescription to be filled? What is the average turnaround for a prescription to be refilled? Please describe the process for each.
g) Do you have a 24 hour phone number that members can call to speak with a pharmacist? To speak with a customer service representative? Can refills be ordered over the phone and online?
h) Describe your internet capabilities with respect to online refills, email notifications, drug information, over the counter purchases and network availability.
i) Describe any safeguards in place in your processing system, for potential drug interactions.
j) Describe your network discounting strategy including percentage of discount on the retail and mail service level and any applicable dispensing or utilization management fees.
k) Pharmacies and 90 day supply of medications.
    i. Do you participate with designated retail pharmacies for member long-term maintenance prescriptions up to a 90-day supply?
    ii. Would the cost to the employee be the same as the mail order cost? Please list any variance.
    iii. Would the cost to the employer be the same as the mail order cost? Would the retail dispensing fees apply? Please list any variance.
l) Does your plan use a formulary? If so:
    i. Advise if the formulary is open or closed.
    ii. Advise if you are willing to create a customized formulary for the Commission.
    iii. Please enclose a copy of your formulary as well as an internet and telephone resource for inquiries regarding the formulary.
    iv. Explain how your formulary list is developed and by whom.
    v. Explain how often your formulary is changed.
    vi. Explain if any exceptions are made to the formulary and describe the process.
m) Do you offer formulary rebates? How often are they distributed? Are there any guarantees? Please explain.
n) Describe how specialty drugs are handled and if there are limitations on how an employee may obtain specialty drugs.
o) Explain if coverage is offered for diabetic supplies and how a member would obtain them. Does the standard copay apply?
p) Describe your approach and philosophy to managing prescription drug costs. Be sure to identify where the drugs are dispensed, contracting approach, utilization review procedures, use of formulary, etc.

q) Describe your Coverage Authorization, Drug Education and Drug Utilization Review (DUR) programs.
r) List any internet-based discounts on non-covered prescriptions or over the counter products you provide.
s) The Commission applies for the employer drug subsidy for Medicare Part D and will require monthly reports from the prescription vendor for this service. What services do you provide with regard to Medicare D and the employer drug subsidy? Do you have dedicated resources for Medicare processes? If so, please explain. Are there any costs associated with these services? If so, provide all costs associated with Medicare D in your cost submittal.

D. DENTAL CARRIERS ONLY

a) Please describe your network including number of dentists, oral surgeons, orthodontists, and other specialists in Pennsylvania, the number outside of Pennsylvania and the percentage of dentists that participate. Is your network accessible to members traveling abroad?
b) Please provide a geo-access report using the following standards: two general dentists, two oral surgeons, two orthodontists and two other specialists within an 8 mile radius.
c) Describe your preauthorization process; applicable procedures, and dollar thresholds.
d) How are the following services covered under your plan?
    i. Anesthesia
    ii. Pediatric dental specialist services
    iii. Hospitalization or attending physician due to the member's general health or physical limitations
    iv. Removal of impacted teeth; bony or soft tissue
    v. Tooth implants
    vi. Extractions for orthodontic purposes
    vii. Periodontics, both surgical and non-surgical
    viii. Therapeutic Periodontal Treatment

E. VISION CARRIERS ONLY

a) Please describe your network including number of optometrists, ophthalmologists and opticians in Pennsylvania, the number outside of Pennsylvania and the percentage of each type of provider that participates.
b) Please provide a geo-access report using the following standards: two optometrists, two ophthalmologists and two opticians within an 8 mile radius.
c) Please list the major “chain” providers in your network.
d) Would the member pay a different cost at a “retail provider” versus an “independent provider?” If yes, please list all providers considered to be a “retail provider” that are located in Pennsylvania.
e) Is the network accredited by an outside organization? If yes, by whom?
f) Advise if you are able to provide wholesale allowances to the Commission.
g) Are the allowances listed in your plan retail or wholesale? If the member receives additional services (i.e., two pairs of glasses), does the member pay the retail or wholesale price on the second service/product?
h) Explain if “Lasik” is an option under your plan, and any additional options of treatment that can be offered under the plan. Please define how you can cover these services or what discounts a member can expect for these services.

i) Can you provide customized allowances for services such as frames and lenses, to give a member an allowance to go toward any balance they may owe on frames/lenses?
j) List any other discounts you can provide or other coverage for items such as non-prescription sunglasses, safety goggles, additional pairs of glasses or contacts or colored contacts? Are there discounts available for supplies such as contact lens cleaning fluids?

Addendum No. 1

RFP #11-10380-3395

Providing Medical, Prescription, Dental and Vision Benefit Plans

Prospective Respondents: You are hereby notified of the following information in regard to the referenced RFP:

REVISIONS

The response date referenced in Part I-11 of the RFP has been extended and revised as follows:

1. **I-11. Response.** To be considered, proposals must be delivered to the Pennsylvania Turnpike Commission's Contracts Administration Department, Attention: Wanda Metzger, on or before ~~**Tuesday, December 20, 2011**~~ **Thursday, December 29, 2011at 12:00 p.m. local time.**

2. In Appendix D, "UCCI Dental Benefit Summary" document has been replaced with "UCCI Dental Benefit Summary – updated," attached. In the initial version, header information for Class 1 services stipulated that Class 1 services are excluded from Annual Program Maximum. This was incorrect for our plan. Class 1 services are not excluded from the Annual Program Maximum, and that stipulation has been removed from the updated version, attached.

ADDITIONS

Insurance Requirements

A. General. Before the execution of a Contract, Provider must provide the Commission with certificates of insurance evidencing the coverage required acceptable to the Commission, as described below. Have all policies endorsed to contain the following clause: "Thirty (30) days written notice of any cancellation, non-renewal, limit or coverage reduction is to be sent to the Commission by Certified Mail." The preceding is subject to existing Commonwealth of Pennsylvania statutory cancellation provisions relating to non-payment of premium and misrepresentation by the insured. Maintain the insurance described herein for the entire duration of the Contract. All insurance policies must be written by an Insurance Company licensed and/or authorized to do business in Pennsylvania and acceptable to the Commission having an A.M. Best's rating of no less than A-, with a financial size category of IX, or better. Have all insurance policies and certificates signed by a resident Pennsylvania Agent of the issuing Company. However, in the case of an eligible surplus lines insurer, have all policies and certificates also signed by a party duly authorized to bind, on behalf of the eligible surplus lines insurer, the certified coverage's.

B. Commercial General Liability Insurance. Commercial general liability insurance (CGL) with limits not less than $1,000,000 each occurrence with a $2,000,000 aggregate. If the CGL contains a general aggregate limit, it shall apply separately each site or location. CGL insurance shall be written

on the Insurance Services Office Inc. (ISO) occurrence form CG 00 01 12 07 (or substitute form providing equivalent coverage) and shall cover liability arising from premises, operations, independent contractors, products completed operations, personal injury and advertising injury, and liability assumed under contract (including the tort liability of another assumed in a business contract but not including breach of contract damages).

C. Business Auto Liability Insurance. Business auto liability insurance with a limit of not less than $1,000,000 each accident. Such insurance shall cover liability, including bodily injury or death and property damage, arising out of any auto (including owned, hired, and non-owned autos). Business auto coverage shall be written on the current ISO form or a substitute form providing equivalent liability coverage.

D. Worker's Compensation and Employer's Liability Insurance. Take out, pay for and maintain during the life of the contract, Worker's Compensation Insurance in statutory required limits for the protection of all employees. Provide, pay for and maintain during the life of the contract, Employer's Liability Insurance in limits of not less than $100,000 bodily injury each accident, $500,000 bodily injury by disease- Policy Limit, and $100,000 bodily injury by disease each employee

E. Professional Liability Insurance. Insurance coverage for Errors and Omissions (Professional Liability Insurance) in an amount not less than $1,000,000. Insurance shall be provided on a form acceptable to the Pennsylvania Turnpike Commission.

QUESTIONS & ANSWERS

Following are the answers to questions submitted in response to the above referenced RFP as of **December 6, 2011.** All of the questions have been listed verbatim, as received by the Pennsylvania Turnpike Commission.

GENERAL QUESTIONS

1. According to the RFP, there are two Medicare Advantage plans currently being offered to the retirees 65 and over, however, MA plans are not being reviewed with this RFP. Would you accept an RFP for just this population?

Answer: Medicare Advantage plans are not included in this RFP and current Medicare Advantage plans offered will remain in place at this time. The Commission will review all proposals submitted that would match our Signature 65 plan as that plan is included in this RFP.

2. We would like clarification as to item #4 of Administrative Requirements on page 15 of 26, which states:

   "You will demonstrate adoption of arrangements to protect the Commission and its affiliates and plan participants from incurring liability for payment of any fees which are your legal obligation, including but not limited to (i) sufficient insolvency and liability insurance, (ii) a contractual arrangement with medical providers affiliated with you that prohibits such providers from holding

any participant liable for payment of any fees which are your obligation, and (iii) other protection from liability for participants as provided by applicable state or federal laws".

Can you please address each portion of item #4 separately so that we understand its intent.

Answer: The Commission's intent is that it not incur liability for fees that are the obligations of another party. To that end, we are asking that vendors demonstrate how they will meet this goal. We cannot provide more comments about subparts i through iii because these subparts were offered as examples of options [indicated by use of the phrase "including but not limited to"] and we do not want to limit consideration to this list if there are other alternatives.

3. Is the Pennsylvania Turnpike Commission exempt from paying premium taxes?

Answer: Yes.

4. Can you please clarify what information you are seeking in regard to question h) under the Network section of the questionnaire (i.e. "List any exceptions or restrictions")?
5. Please provide a clarification for an item in V. Questionnaire:

   A. GENERAL INFORMATION – ALL CARRIERS

   NETWORK

   h) List any exceptions or restrictions.

   Please further define what information the PTC is seeking regarding exceptions or restrictions to networks. For example, is the PTC inquiring about limits that might apply based on state law, such as that certain provider types are not eligible for network status?

Answer (#4 & #5): Regions not covered, types of providers not covered, etc.

6. Please provide clarification of the following statement from Page 13 of 26:

   ⇒ Please quote all programs using the assumption that you may not be awarded all of the programs and may in fact be one of many carriers providing services to the Commission.

   Is this intended to mean that various vendors could be administering one of the programs, i.e., multiple or regional vendors for drug benefits or medical benefits OR multiple vendors for the multiple lines of business?

Answer: Both possibilities listed above are options; various vendors could be administering one of the programs (i.e., multiple or regional vendors for one program), and/or multiple vendors for multiples lines of business.

7. Your RFP objective is for vendors for administrative services and to reduce health care costs. Are you open to proposals which carve-out Medicare eligible retirees to a fully-insured group medical and prescription plan?

Answer: The Commission will consider all proposals submitted *for benefit plans included in this RFP*.

8. Each proposal should be submitted in eight hard copies and two complete and exact copies of the technical proposal on CD-ROM in Microsoft Office or Microsoft Office-compatible format to the Contracts Administration Department. Do you want all 8 hard copies to be original? Please confirm you are looking for an original officers signature in each of the 8 hard copies.

Answer: At minimum, one hard copy must be original, with the officer's signature. It is okay to have the others be copies of the original.

9. Can an employee with authority to binder the company sign the Proposal Requirements Section of the RFP (i.e. Page 18 of 26)?

Answer: The Proposal Requirements section must be signed by an executive officer of the company as stated on page 15 of the RFP.

10. Regarding Section I-8 (*Section II-8*), Can you please provide further clarification around what you mean by "assumptions"? Does this mean we need to expressing state what is, and is not, included in our base pricing?

Answer: Yes, you need to state what is, and is not, included in your base pricing.

11. Regarding Section I-12, is it acceptable to restart the page numbering in different documents, as long it they are in separately marked off sections?

Answer: Yes.

12. Can you please provide rates on all current products?

Answer: Administrative fees will not be provided. COBRA rate history was included in Appendix E of the RFP.

13. Can you please provide the preferred rate ratios that the Commission would like used for the 5 tier rate structure?
14. Currently, the Commission's dental rate renewal shows 5-tiers; however, the rate is the same for child and children. Please clarify if you want to see a separate rate for Employee + Child and Employee + Children. Also, please list the rate relatives that we should use.
15. We can only offer a 4 tier rate structure on fully insured plans because the employee+child and the employee+children rates are the same. Is this sufficient? Can you send over the tier definition for the 5 tier rates currently being used?

Answer (#13 - #15): Rates should be provided to the Commission in the 5-tier structure format (Individual, Two Person, Parent+Child, Parent+Children & Family). If a rate for two (or more) tiers is the same, it should be listed that way. To assist in your calculations, an updated COBRA Rate History document is attached, with a new column added for rate ratios/rate relatives that each vendor used for the March 2012 renewal rates.

16. Can you please specify what kind of customization the Commission is looking for on their ID cards (i.e. Custom logos, customizing the wording on the front/back of the ID card, etc.)?

Answer: *Potential for* custom logo, copay information if not already listed, customer service phone numbers if not already listed, website if not already listed, etc.

17. Can you please specify what kind of customization the Commission is looking for their handbooks? (i.e. an idea of overall content and/or document length? How much detail would the handbook include? Can you provide a sample?)

Answer: Three examples of the Commission's current benefit handbooks (booklets) were attached in Appendix A: "Highmark PPO Booklet," "Highmark Signature 65 Booklet" and "Highmark ClassicBlue Booklet."

18. Would the Commission prefer to be claim fiduciary? Or is the preference for (*vendor*) to assume Claim Fiduciary?

Answer: The Commission will be the claim fiduciary.

19. We acknowledge that the cost submittal should be separate from the technical. Could you please confirm if eight cost submittals are required, and if the cost submittal can be sent in the same shipping package?

Answer: Yes, eight cost submittals are required. They can be in the same shipping package; but cost submittal must be sealed separately from the technical submittal in the shipping package.

20. Can you please confirm that the dental, vision, and Rx lines of business are currently ASO?

Answer: Yes, all lines of business in this RFP are ASO.

21. Has the Pennsylvania Turnpike Commission instituted any benefit changes (on any of the plan designs – medical/Rx/dental/vision) over the term of the claims experience provided? If so, can you please provide information on the changes?

Answer: The only change made since March 1, 2008 (outside of annual preventive schedule changes and mandatory regulatory changes), was to the dental plan. Effective March 1, 2011, the Commission added an additional cleaning for women during pregnancy.

22. The RFP states that a separate RFP was sent out for the stop loss bidding. Would it be possible for (*vendor*) to provide a proposal for the stop loss as well?

Answer: All vendors are allowed to bid on RFPs posted to the Commission's website. The Stop Loss proposals are due December 28, 2011.

23. Under the MBE/WBE diversity arrangements, can you advise what dollar or percent of administrative cost should be allocated?

Answer: No specific dollar or percent of administrative cost is required.

24. We understand the PTC pays for the premium for actives and retirees prior to age 65 for dental and vision. What % of premium is paid for the retirees after age 65?

Answer: There is no retiree contribution for dental and vision.

25. We understand that the dental and vision is currently self-funded now. Can you advise why also looking at fully insured arrangements.

Answer: The Commission will review all funding arrangements/options submitted to see what is most advantageous.

26. Can you provide the current administrative fee for the dental and vision.

Answer: This information will not be provided.

27. Are the COBRA rates a true rate Equivalent or do they have a 2% COBRA admin fee added to the rates?

Answer: True rate equivalent. The 2% COBRA admin fee has NOT been added to the rates provided.

28. Can we get the questionnaire portion of the RFP in word format? This prevents us from retyping the questions.
29. Please provide a copy of the RFP in a Word document as it is unable to be worked with in its current PDF format.

Answer (#26 & 27): RFP in Word format is attached.

30. Regarding the RFP. Under Part II, Information Required from Proposers, there is no mention of which section should include our responses to Part V, Questionnaire. Should this be included as an appendix since it is relevant, but not application to the enumerated categories listed?
31. Please provide some clarification for Part II-Information Required From Proposers. It states: "To be considered, the proposal must respond to all requirements in this part of the RFP. Any other information thought to be relevant, but not applicable to the enumerated categories, should be provided as an appendix to the proposal." In this case, where should the Proposal Requirements from Part IV- Work Statement and Part V- Questionnaire be included? Should this be sealed with the technical submittal of Part II? Or should it be created as a separate document?

Answer (#28 & #29): Part IV-Work Statement and Part V-Questionnaire should be attached to Part II-3-Work Plan.

MEDICAL QUESTIONS

32. In order to make our response to questionnaire Section B. (Medical Carriers Only) Question "a)" more manageable, would you like us to provide network information for regions where only more than 25 employees participate?

Answer: No, the Commission would like to analyze full network information.

33. The file titled "Medical Payment Totals by Month and plan Year" in Appendix A contains various group descriptions (19 different groups in August of 2011). Can you provide further detail on each of the groups listed – i.e. what plan designs, medical and Rx, are offered in each group?

Answer: The group descriptions in the above-referenced file are only related to medical coverage. Group descriptors were located in the second tab of the worksheet. Several groups have the same plan; one PPO plan, one ClassicBlue plan, and one Signature 65 plan. Additional information on the three plans was included in Appendix A. Prescription plan designations are solely based on employment status (active or retired) and retiree age (under or over age 65).

34. Does the medical claims information include claims above the stop loss attachment point?

Answer: Yes.

PRESCRIPTION QUESTIONS

35. Is there any way to add the "daily dosage" to the claims file?

Answer: No.

36. Are there any Prior Authorization or Step edits in place and if so, could you please provide detail on the edits.

Answer: Drugs requiring prior authorizations were listed in Appendix B, in the "Aetna Prescription Classes of Drugs 01-05-11" spreadsheet. There are no step edits in place.

37. Also, pertaining to the Rx plan, I do not see that Specialty Injectible medications are broken out as a tier. Can you confirm that you do not use a Specialty Pharmacy vendor for high cost injectible drugs? If not, do members use the retail and regular mail order pharmacies to get these prescriptions at the same copayment levels as regular drugs?

Answer: The Commission uses Aetna's Specialty Pharmacy and members pay the applicable Retail copay for a 30 day supply. Transplant patients are able to get a 90 day supply for their medications.

38. In the Prescription Provider Utilization report from Appendix B, is the data shown for the Actives and Under 65 plans? If so, can you also provide information on the claims for the over 65 Retiree plan? If not, can you break out the claims information by plan design/class so we can decipher where the various claims should be applied?

Answer: The Prescription Provider Utilization report from Appendix B contains data for all 3 groups; actives, under age 65 retirees, and age 65 or over retirees.

DENTAL QUESTIONS

39. We noted the total in-network utilization percentage. However, what is the utilization percentage between the UCCI Advantage network and the UCCI NFFS network?

Answer: Please see updated UCCI network spreadsheet which includes UCCI Advantage network column and UCCI NFFS network column.

40. Please provide the current funding method.

Answer: Self-insured.

41. Please provide PA Turnpike Commission's contribution strategy.

Answer: The Commission pays all claims and administrative fees for the dental plan; employees/retirees do not contribute.

42. Please provide the current fee.

Answer: Current administrative fees will not be provided.

43. Should we maintenance maximums based on a calendar or contract year?

Answer: Calendar year.

44. Dental Carriers Only – question d); viii – Therapeutic Periodontal Treatment. Please clarify what you are looking for here this can encompass a variety of services. If you are able to provide procedure codes, that would be helpful.

Answer: Please provide information on how Periodontal Treatment currently covered under our UCCI dental plan (descriptors in Appendix D, "UCCI Dental Benefit Summary") would be covered under the plan(s) you are proposing.

45. In regards to the dental benefits, can you share a listing of Non-Network providers utilized by your population, along with contracts and claims by month at those providers? This would help us analyze any network advantages and savings that may be available with (*vendor*) versus current.

Answer: Non-Network providers utilized by the Commission in a one-year timeframe were included in Appendix D, in the document "All Providers Paid 9-1-10 thru 8-31-11" excel spreadsheet. Non-network providers would have an "N" indicator in the "In-Network" column on the original spreadsheet; in the updated spreadsheet (attached), the corresponding column is titled Adv+ Network (column N).

VISION QUESTIONS

46. Please clarify "plan information" vision see RFP pages 12 & 13 of 26. What portion of the vision only premium is paid by the over 65 retired non-union employees?

Answer: There is no retiree contribution for the vision plan.

47. How are retirees enrolled into the plan? Does the T.C. do enrollment and supply final data or will carriers be required to enroll the retirees?

Answer: The Commission enrolls the retirees into the plan in our SAP (HRIS) system. The carrier will typically enroll the retirees into the plan straight from the interface file.

48. We can offer a wholesale or retail based frame benefit on a self insured plan and a retail benefit on a fully insured plan but cannot offer both on the same plan. Would you like us to include the richer wholesale benefit to be utilized at all providers?

Answer: All wholesale is preferred, but the Commission will consider all proposals submitted.

49. The current plan has an unlimited benefit for standard daily contact lenses but a $300 allowance on all others. Although daily wear contacts are much less frequently worn than the others, we cannot offer different contact lens benefit for disposables, daily wear or extended wear. In addition an unlimited benefit would not allow us to quote a fully insured option. Would you like a quote with the $300 contact lens benefit on all contact lenses?

Answer: You may quote the contacts lens benefit as you described.

50. The current plan has a 24 month frequency for contact lenses for adults and 12 months for dependent children but a 12 month frequency for the contact lens fitting and evaluation for all members. Is it acceptable to have the lens fitting and evaluation frequency match the contact lens frequency since this benefit is only used when a member is purchasing contact lenses?

Answer: The Commission will review all proposals submitted. To clarify current vision frequencies:

Group	Description	Frequency
All members	Eye exam & evaluation *and* fitting of contacts	12 months
Employees/Retirees	Prescription: eyeglasses, contact lenses *or* sunglasses	12 months
Dependents to age 19	Prescription: eyeglasses *or* contact lenses	12 months
Spouse/Dependents age 19 or over	Prescription; eyeglasses *or* contact lenses	24 months

51. A requirement states that Evidence of Coverage needs to be sent to employees. Please confirm that these need to be mailed to employees homes. Also is a welcome kit that includes a personalized ID card, benefits description, how to access the benefit and HIPAA privacy notice sufficient for this evidence of coverage?

Answer: Evidence of Coverage would only be required of medical and prescription vendors after coverage cancellations. These notices are mailed to employees' homes.

52. Can you please clarify this request is part of the current plan or an alternate plan design which is in the questionnaire section FOR VISION CARRIERS ONLY? Can you please give an example of how this benefit would work to make the request is understood?

    i) Can you provide customized allowances for services such as frames and lenses, to give a member an allowance to go toward any balance they may owe on frames/lenses?

Answer: The Commission previously had a $50 customized allowance in its vision plan, that the member could apply to services that they would have to pay out-of-pocket. This question is asking if you have similar capabilities.

53. Can you please clarify this notation under the Highmark benefit summary? The benefits summary states that the materials benefit (lenses, frame and contact lenses) are covered once every 24 months but the statement below states a 12 month frequency.

    (6) The material benefit for employees/retirees includes: one pair of prescription eyeglasses, or one pair of prescription sunglasses (Polarized and ultraviolet coating lenses are covered in full) or prescription contact lenses every 12 months.

Answer: <u>Employees/Retirees</u> are eligible for the items listed every 12 months; <u>other members over age 19</u> are eligible for the items listed every 24 months. See frequency table shown in #51 above.

All other terms, conditions and requirements of the original RFP dated **November 23, 2011** remain unchanged unless modified by this Addendum.