REQUEST FOR PROPOSALS FOR

Benefit Consultant

ISSUING OFFICE

Pennsylvania Turnpike Commission

Human Resources Department

16-10380-7456

DATE OF ISSUANCE

July 1, 2016

REQUEST FOR PROPOSALS FOR

Benefit Consultant

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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 a benefit consultant to analyze, procure and negotiate employee healthcare coverage.

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. The Commission is seeking proposals from qualified companies to serve as the benefit consultant on behalf of the Commission for various benefit vendors. A detailed work statement is provided 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. 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, responsive and capable of performing the work.

I-6. Contractor Integrity Provisions. Contractor Integrity Provisions will apply to this contract upon award and the awarded vendor may be required to complete a Background Qualifications Questionnaire prior to entering into an Agreement with the Commission and attend annual ethics training provided by the Commission. Proposers can find these two documents on the Commissions website at www.paturnpike.com (Doing Business, General Information, Integrity Provisions).

Include full disclosure of any potential conflict with the State Adverse Interest of State Advisor or Consultant Statute by the prime or any subconsultant. If there is no adverse interest you shall include the following statement: "I have reviewed the State Adverse Interest Statute and determined that there is no adverse interest for anyone on this Agreement team." This information should be included in your transmittal letter/cover page or executive summary.

I-7. 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-8. 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-9. 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.10. 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 16-10380-7456** in the Subject Line to be received no later than **2:00 PM local time on Monday, July 18, 2016**. Proposers shall use the form provided in **Appendix A** to submit the questions. All questions and written answers will be posted to the website as an addendum to and become part of this RFP.

I-11. 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-12. Response. To be considered, proposals must be delivered to the Pennsylvania Turnpike Commission's Contracts Administration Department, Attention: Wanda Metzger, on or before **2:00 PM local time on Thursday, August 11, 2016.** 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 the Contracts Administration Department 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-13. 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 **seven (7)** hard copies of the Technical Submittal, **seven (7)** hard copies of the Diverse Business (DB) participation submittal, and **seven (7)** hard copies of the Cost Submittal. In addition to the hard copies of the proposal, two **complete and exact copies** of the Technical, Cost and DB submittals, along with all requested documents on CD-ROM or Flash Drive in Microsoft Office or Microsoft Office-compatible format. The electronic copy must be a mirror image of the hard copy. Proposer should ensure that there is no costing information in the technical submittal. The CD or Flash drive should clearly identify the Proposer and include the name and version number of the virus scanning software that was used to scan the CD or Flash drive before it was submitted. The Proposer shall present the proposal to the Contracts Administration Department only. No other distribution of proposals will be made by the Proposer. Each proposal page should be numbered for ease of reference.

An official authorized to bind the Proposer to its provisions must sign the proposal. If the official signs the Proposal Cover Sheet (**Appendix B** to this RFP) and the Proposal Cover Sheet is attached to the proposal, the requirement will be met. For this RFP, the proposal must remain valid for at least 120 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 fax notice (fax number (717) 986-8714) received at the Commission's address for proposal delivery prior to the exact hour and date specified for proposal receipt.

Overnight Delivery Address:
Contracts Administration Department
Attn: Wanda Metzger
PA Turnpike Commission
700 South Eisenhower Blvd.
Middletown, PA 17057

US Mail Delivery Address:
Contracts Administration Department
Attn: Wanda Metzger
PA Turnpike Commission
P.O. Box 67676
Harrisburg, PA 17106

However, if the Proposer chooses to attempt to provide such written notice by fax transmission, the Commission shall not be responsible or liable for errors in fax transmission. A proposal may also be withdrawn in person by a Proposer or its authorized representative, provided his/her identity is made known and he/she 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 solicitation.

I-14. 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-15. Discussions for Clarification. Proposers who submit proposals may be required to make an oral or written clarification of their proposals to the Issuing Office through the Contract Administration Department to ensure thorough mutual understanding and Proposer responsiveness to the solicitation requirements. The Issuing Office through the Contract Administration Department will initiate requests for clarification.

I-16. 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-17. 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-18. 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-19. 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-20. 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-21. Commission Participation. Unless specifically noted in this section, Proposers must provide all services to complete the identified work.

I-22. Cost Submittal. The cost submittal shall be placed in a separately sealed envelope within the sealed proposal and kept separate from the technical submittal.

I-23. Term of Contract. The term of the contract will commence on the effective date (as defined below) and will end one (1) year after the effective date, or after implementation with benefit vendor(s) whichever occurs later. If the Commission utilizes the continuation of services option it would be for up to four (4), one (1) 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-24. 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 response section of 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.

I-25. Indemnification. The Proposer shall be responsible for, and shall indemnify, defend, and hold harmless the Commission and its Commissioners, officers, employees, and agents from any claim, liability, damages, losses, causes of action, and expenses, including reasonable attorneys' fees, arising from damage to life or bodily injury or real or tangible personal property caused by the negligence or other tortious acts, errors, and omissions of Proposer, its employees, or its subcontractors while engaged in performing the work of the Agreement or while present on the Commission's premises, and for breach of the Agreement regarding the use or nondisclosure of proprietary and confidential information where it is determined that Proposer is responsible for any use of such information not permitted by the Agreement. The indemnification obligation shall not be limited in any way by any limitation on the amount or type of damages, compensation or benefits payable by or for Contractor or its subcontractors under Workers' Compensation Acts, Disability Benefits Acts, or other Employee Benefit Act.

I-26. Insurance. Proposer will comply with the Insurance requirements as described in **Appendix C** - Insurance Specification.

I-27. Diverse Business (DB) Requirements. Proposer will comply with the DB Requirements as described in **Appendix D** – Diverse Business (DB) Requirements.

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. All cost data relating to this proposal and all Diverse Business cost data should be kept separate from and not included in the Technical Submittal. Each proposal shall consist of three separately sealed submittals:

1. Technical Submittal, which shall be a response to RFP **Part II, Sections II-1** through **II-3;**

2. Diverse Business Participation Submittal, in response to RFP **Part II, Section II-4**; and

3. Cost Submittal, in response to RFP **Part II, Section II-5**.

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 Technical Submittal.

A. Proposal Cover Sheet **(See Appendix B)**
Show the name of your firm, Federal I.D. number, address, name of contact person, contact person's email and telephone number date and the subject: Benefit Consultant**, RFP 16-10380-7456.** Appendix B must be signed by an individual who is authorized to negotiate terms, render binding decisions and commit your firm's resources**.** In addition it is required that all information requested in Appendix B be provided including information pertaining to location of office performing the work, contact information, listing of all Pennsylvania offices and total number of Pennsylvania employees, and location of company headquarters.

B. Table of Contents
Include a clear identification of the material by section and by page number.

C. Executive Summary
Summarize your understanding of the work to be done and make a positive commitment to perform the work necessary. This section should summarize the key points of your submittal. (Limit to two pages.) Include in this section or in a transmittal letter/cover page a statement regarding full disclosure of any potential conflict with the State Adverse Interest of State Advisor or Consultant Statute as instructed in Proposal Section 1.6 Contractor Integrity Provisions.

D. Firm Overview

Provide a brief history and description of your firm's business organization and its benefit consultant service expertise and experience as it relates to the requirements discussed in Part IV of this RFP. Include the location of offices and the number and types of consultants or other relevant professional staff in each office. Discuss your firm's presence in and commitment to the Commonwealth of Pennsylvania. Include a discussion of the specific expertise and services that distinguish your firm.

E. Personnel

Provide the names, proposed roles, background and experience, current professional licenses, office location and availability of the consulting personnel that would perform the benefit consultant services as described in Part IV of this RFP. Specifically identify the primary person(s) who will be responsible for managing the relationship with the Commission during this endeavor. Proposer must submit a current resume for all proposed staff listing relevant experience and applicable professional affiliations.

F. Relevant Experience and Expertise

Provide a narrative statement regarding your benefit consultant services expertise and experience as it relates to Part IV of this RFP. Additionally include a statement regarding your understanding of the requirements as outlined in this RFP and your ability to provide benefit consultant services in accordance with the same.

Describe your firm's experience in providing similar benefit consultant services to other clients, especially other governmental entities and/or similar public/private sector transportation organizations. Describe the business practices that enable you to complete these tasks in an efficient, timely and, at times, expeditious manner.

Provide a list of three references of clients for which your firm has performed similar work, as described in this RFP, within the past three years.

Include a statement regarding any other specialized benefit consultant services your firm may offer.

G. Approach

Provide a description of the proposed approach/methodology that you will follow, along with a project plan and realistic timeline that identifies the phases and tasks required to complete the services defined in Part IV. Include in this section the deliverables and reports that will be provided, the project controls that will be used, and the tasks that will be performed.

Provide a description of all of the deliverables that you will provide as an output of the project plan. Provide relevant samples of deliverables and project plans from similar services that your firm was primarily responsible for producing.

II-2 Objections and Additions to Standard Contract Terms and Conditions.

The proposer will identify which, if any, of the terms and conditions (contained in **Appendix E, Standard Agreement**) it would like to negotiate and what additional terms and conditions

the proposer would like to add to the standard contract terms and conditions. The Proposer's failure to make a submission under this paragraph will result in its waiving its right to do so later, but the Issuing Office may consider late objections and requests for additions if to do so, in the Issuing Office's sole discretion, would be in the best interest of the Commission. The Issuing Office may, in its sole discretion, accept or reject any requested changes to the standard contract terms and conditions. The Proposer shall not request changes to the other provisions of the RFP, nor shall the Proposer request to completely substitute its own terms and conditions for **Appendix E**. All terms and conditions must appear in one integrated contract. The Issuing Office will not accept references to the Proposer's, or any other, online guides or online terms and conditions contained in any proposal.

Regardless of any objections set out in its proposal, the Proposer must submit its proposal, including the cost proposal, on the basis of the terms and conditions set out in **Appendix E**. The Issuing Office will reject any proposal that is conditioned on the negotiation of the terms and conditions set out in **Appendix E** or to other provisions of the RFP as specifically identified above.

II-3 Business Associate Agreement

The awarded proposer will be required to complete the Business Associate Agreement (Exhibit F) upon award of the contract.

II-4 Diverse Business (DB) Requirements (Appendix D).

The Commission's Diverse Business (DB) Requirements for this procurement and a resulting contract are identified in Appendix D. There is no minimum participation level (MPL) for DBs established for this contract. However, the utilization of DBs are encouraged and will be considered as a criteria in the evaluation of proposals and may be considered as a factor in the Commission's selection of a firm for this contract.

The proposer must include in its DB participation submittal that it meets the requirements set forth in the Commission's DB Requirements - Appendix D. In particular, the proposer shall address the section of the DB Requirements labeled, "Actions Required by Proposer during the procurement/consultant selection phase". In addition, the DB participation submittal shall indicate the amount of DB participation incurred in the proposal in terms of dollars committed or percentage of total contract amount.

II-5 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 AND ON A CD-ROM, 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 Issuing Office may reject the proposal. Proposers should direct in writing to the Issuing Office pursuant to Part I-10, Questions and Answers 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.

The Proposer must complete **Appendix G - C**ost Breakdown. Proposer must provide information that identifies the Resources (by position) that will be devoted to the effort, the average loaded rate for those resources and the number of hours each will devote to the effort. The table must also identify any other direct costs that went into calculating the Proposer's cost. The sum of the loaded rates times the number of hours for each position, plus the other direct costs must equal the total fixed price cost. 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 to 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 shall be (a) timely received from a Proposer; and (b) properly signed by the Proposer.

III-2. Technical Nonconforming Proposals. The two (2) Mandatory Responsiveness Requirements set forth in Section III-1 above (a&b) are the only RFP requirements that the Commission will consider to be non-waivable. The Issuing Office reserves the right, in its sole discretion, to (1) waive any other technical or immaterial nonconformities in the proposal, (2) allow the Proposer to cure the nonconformity, or (3) consider the nonconformity in the evaluation of the proposal.

III-3. Proposal Evaluation. Proposals will be reviewed, evaluated, and rated by a Technical Evaluation Team (TET) of qualified personnel based on the evaluation criteria listed below. The TET will present the evaluations to the Professional Services Procurement Committee (PSPC). The PSPC will review the TET's evaluation and provide the Commission with the firm(s) determined to be highly recommended for this assignment.

The Commission will select the most highly qualified firm for the assignment or the firm whose proposal is determined to be most advantageous to the Commission by considering the TET's evaluation and the PSPC's determination as to each firm's rating. In making the PSPC's determination and the Commission's decision, additional selection factors may be considered taking into account the estimated value, scope, complexity and professional nature of the services to be rendered and any other relevant circumstances. Additional selection factors may include, when applicable, the following: geographic location and proximity of the firm, firm's Pennsylvania presence or utilization of Pennsylvania employees for the assignment; equitable distribution of work; diversity inclusion; and any other relevant factors as determined as appropriate by the Commission.

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-4. Evaluation Criteria. The following criteria will be used, in order of relative importance from the highest to the lowest, in evaluating each proposal

1. Proposer and Personnel Qualifications and Experience
    a. Proposer's relevant experience and expertise in conducting benefit consulting as it relates to the requirements discussed in Part IV of this RFP.
    b. Qualifications, experience and competency of professional personnel who will be assigned to the contract by the Proposer including tenure with firm, length of time in the industry and type of experience.
    c. Financial ability of the Proposer to undertake a project of this size.
    d. Response of references if the Commission elects to solicit them.

2. Approach
    a. Understanding of the Commission's needs and scope of work.
    b. Soundness of proposed approach, methodology, and deliverables for conducting benefit consulting as it relates to the requirements discussed in Part IV of this RFP.
    c. Responsiveness to the Commissions desire for expeditious timeline for completion.
    d. Quality, completeness and applicability of sample deliverables provided.
    e. Responsiveness, organization, and clarity of Proposal.

3. 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.

4. Commitment to Diversity and Inclusion**.**
    This refers to the inclusion of DB firms, as described in Part II-4. Participation may be measured in terms of total dollars committed or percentage of total contract amount to certified DB firms.

PART IV

WORK STATEMENT

IV-1. Objectives.

a. General. The Commission is seeking proposals from a firm that will devote exclusive time to create a health benefit RFP, evaluate and analyze the proposals received in response to the RFP for health benefits, as well as provide the advice and lead negotiations for best and final rates and contract terms with benefit providers. This RFP only includes consulting services for medical, dental, vision, prescription drugs and medical advantage plans. Our current vendors are Medical - Highmark Blue Shield and Aetna, Prescription - Aetna, Dental – United Concordia, and Vision - Highmark Vision (through Davis Vision).

b. Specific. The Commission is soliciting competitive proposals for a benefit consultant to procure, evaluate, analyze and provide advice regarding benefit proposals received and lead individual negotiations with medical, prescription, dental and vision providers. The selected vendor will prepare a health benefit RFP, compile information, analyze proposals received and prepare recommendations/presentations for Executive Staff. The effective date of the new vendors will be January 1, 2018 as the existing benefit contracts expire December 31, 2017.

Additionally, the Commission is seeking possible continuation of benefit consulting services to advise and provide guidance on the Affordable Health Care Act and assist with day-to-day management of the benefit plans and vendors.

IV-2. Nature and Scope of the Project. The Commission is an independent agency of the Commonwealth of Pennsylvania. As a government agency, the Commission is not governed by the rules of, regulations, or legislative requirements of ERISA.

The Pennsylvania Turnpike is a key transportation route within the Commonwealth of Pennsylvania and a vital link in the network of the eastern United States. The Pennsylvania Turnpike is 552 miles in length with 68 fare collection facilities, 17 service plazas and 1 welcome center, 27 maintenance buildings, 8 police barracks and 5 tunnels. For more information go to (www.paturnpike.com).

As of May 1, 2016, there were 485 non-union and 1,585 Teamsters' union employees of the Commission who work in over 116 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 approximately 1,550 retirees of the Commission.

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 the following medical plans; a PPO plan for active employees and retirees under the age of 65, a Signature 65 Medicare wrap-a-round plan and four Medicare advantage plans for retirees age 65 and over. The Commission offers three (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/non-union employees and retirees. Additionally, The Commission offers one

dental plan and one vision plan, both of which are available only to non-union employees and retirees. The administration of COBRA continuation coverage is currently outsourced and will be included in the health benefits RFP. The Commission is self-insured and pays administrative fees to the medical, prescription, dental and vision providers. The Medicare advantage plans are fully insured. The Commission also has stop loss insurance which covers more than 2,400 active employees and under age 65 retirees. The Commission is not currently working with a benefits consultant.

The Commission has collective bargaining agreements with the Teamsters. The current contract expires on September 30, 2019.

Summaries of the benefit plans are listed in **Appendix H** currently offered by the Commission, for which the Commission would be soliciting new bids/proposals.

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 and outcome achieved through the execution of your contracted services.

IV-4. Tasks. Perform the full range of services related to the analysis, selection and negotiation of the Commission's benefit plans and providers. The tasks involved in providing these services are listed in Section IV-4A.

A. Vendor Selection and Contract Implementation

The selected consultant will:

a. Prepare a detailed health benefit RFP, procure, evaluate, analyze and negotiate all pricing proposals submitted; both for self-insured and fully-insured benefit plans, and negotiate best and final offers/rates with final vendors in consideration.

b. Travel to the Commission's Central Administration Building in Middletown, PA to discuss the RFP and to present analyses at Professional Services Procurement Committee (PSPC) and formal Commission meetings. Approximately 4-6 meetings. In addition, participation in phone calls will be as necessary to remain on schedule.

c. Determine if benefit plan parameters and provisions under each proposal have been met, including obligations under the collective bargaining agreements.

d. Following a preliminary analysis of proposals select medical, prescription, dental and vision vendors to give oral presentations at the Commission based on their ability to meet the needs and obligations of the Commission.

e. Prepare questions for the vendor presentations based on preliminary analysis of proposals. Attend and lead vendor presentations. The number of presentations for each benefit program has not been determined (estimate 3 presentations per line of business).

f. Determine the most practical and economical methods for benefit programs by developing comparative illustrations. Complete a comparison of geo access data, provider disruption reports, compilation of RFP questionnaire responses, performance guarantees, multiple year

agreements, access fees and a prescription ingredient cost comparison based on usage for the Commission for 2015 and any other comparisons as needed.

g. Negotiate and confirm final terms with selected medical, prescription, dental and vision providers. This includes the final negotiation and confirmation of best and final rates, benefit levels, plan design and terms and conditions of coverage. Negotiate/confirm retention rates and/or funding methods with all providers.

h. Provide the Commission with an initial comparative service analysis of respondents including benefit levels, plan design, provider disruption, etc. for each line of business for review. After the initial review of the plans and ability to meet the Commission's needs, the costs will be provided to the consultant for comparison.

i. Provide guidance and vendor selection recommendations to Human Resources regarding pros and cons of the vendors with respect to published evaluation criteria from the RFP prior to the final narrative evaluation.

j. Provide a final narrative evaluation which includes each vendor's strengths and weaknesses, final recommendation ratings, (Highly Recommended, Recommended, Not Recommend) for vendor selections and supporting rationale for the determination. Provide the Commission with a separate cost and rate analysis. The consultant will present both of these at the PSPC and the formal Commission meetings.

k. Establish specific implementation timelines and assist the Commission in resolving problems associated with the implementation of employee benefit programs. Attending weekly calls with the selected vendors during implementation. Act as liaison to resolve issues and make recommended solutions.

l. The consultant will not be required to attend open enrollment meetings for Commission employees.

m. Ensure that selected plans are in compliance with all laws and regulations related to employee benefits. Advise the Commission of any new developments in the law and employee benefit programs on an ongoing basis during the implementation phase.

n. Obtain, negotiate and finalize the contracts <u>prior to the plan effective dates</u>, in accordance with the Commission's Standard Contract Terms and Conditions.

Additionally, the Commission may evaluate continuing consultant services after the contracts are implemented. The following ongoing services must be priced separately since this is an avenue the Commission is exploring at this time.

B. <u>Continuation/Ongoing Services</u>

a. Advise the Commission of any new developments with the Affordable Care Act and employee benefit programs on an ongoing basis. Assist the Commission with implementing any changes as a result. Research and provide guidance on other changes to health plans based on recommended updated standards of care.

b. Coordinate claim audits with internal auditors and benefit providers. Assist in resolving any issues that may arise as a result of the audit.

c. Work with vendors on quotes for alternate plan designs or plan changes, i.e. management benefit changes or for contract negotiations. Current contract does not end until September 30, 2019.

d. Participate by phone and/or attend meetings as necessary. (Estimate one a month)

e. Liaison for the Commission with the vendor regarding complex benefit issues.

f. Review and provide analysis of plan utilization and annual renewal rates. Compile and provide new rates to the Cobra vendor.

g. Review benefit reports quarterly and advises of any issues or concerns regarding usage or inappropriate payment of claims, i.e. paying for prescription drugs not covered under the Commission's plans.

h. Coordinate and oversee the performance of all related services provided healthcare vendors, underwriters, and/or other arranged or bundled service providers.

i. Assist with the annual Medicare D application and attestation.

j. Research and provide guidance on wellness program tracking system.

k. Work with vendors to update contracts and necessary and to renew contracts based on allotted renewals.

l. Other ongoing consistent services (please list ongoing services you are able to provide).

IV-5. Reports and Project Control

a. Task Plan. A work plan for each task that identifies the work elements of each task, the resources assigned to the task, and the time allotted to each element and the deliverable items to be produced.

b. Status Report. A periodic weekly telephonic progress report during RFP preparation and evaluation of proposals covering activities, problems, and recommendations; the report should be keyed to the work plan developed by the Proposer in its proposal, as amended or approved by the Commission.

c. Problem Identification Report. An "as required" report, identifying problem areas. The report should describe the problem and its impact on the overall selection of the vendors. It should list advantages and disadvantages of each, and include Proposer recommendations with supporting rationale.

d. Final Reports.

1. Recommend a time-phased work plan for the RFP, vendor selection, contract approval and plan implementation. New vendors must be in place by January 1, 2018.

2. A comparison of geo access data, provider disruption reports, review/compilation of questionnaire responses, performance guarantees and multiple year agreements.

3. Prescription ingredient cost comparison based on usage for the Commission for 2015.

4. A final narrative evaluation of all the providers which includes strengths and weakness and supporting rationale for the recommendation.

5. A final cost and rate comparison and analysis.

Appendix A
Proposer Questions Form

Proposer Questions

Pennsylvania Turnpike Commission (PTC) **RFP #: 16-10380-7456**

#	Page	Section	Section Description	Proposer Question	Commission Response
1.					
2.					
3.					
4.					

APPENDIX B – PROPOSAL COVER SHEET
Pennsylvania Turnpike Commission
BENEFIT CONSULTANT

RFP# 16-10380-7456

Enclosed in three separately sealed submittals is the proposal for the Proposer identified below for the above referenced RFP:

Proposer Information:	
Proposer Name	
Proposer Mailing Address	
Proposer Website	
Proposer Contact Person/Title	
Contact Person's Phone Number	
Contact Person's Fax Number	
Contact Person's Email Address	
Proposer Federal ID Number	
Location of Headquarters	
Location of Office(s) Performing the Work	
Listing of all Pennsylvania Offices and Total Number of Pennsylvania Employees	

Submittals Enclosed and Separately Sealed:

☐ Technical Submittal ☐ Diverse Business Participation Submittal ☐ Cost Submittal	
Signature	
Signature of an official authorized to bind the Proposer to the provisions contained in the Proposer's proposal:	_____
Print Name	
Title	

An official authorized to bind the Proposer to its provisions must sign the proposal. If the official signs this Proposal Cover Sheet and the Proposal Cover Sheet is attached to the proposal, the requirement will be met.

INSURANCE SPECIFICATION "C"
MINIMUM INSURANCE REQUIREMENTS

The Pennsylvania Turnpike Commission

Prior to the commencement of any work and until completion and final payment is made for the work / final acceptance of the work, the Contractor will provide and maintain the following minimum levels of insurance at Contractor's own expense. The cost of the required insurance shall be included in the Contractor's cost proposal and no adjustment shall be made to the contract price on account of such costs. The term Contractor shall include Subcontractors and Sub-Subcontractors of every tier. Contractor shall furnish Certificates of Insurance evidencing and reflecting the effective date of coverage as outlined below. In no event shall Work be performed until the required evidence of Insurance is provided in accordance with the terms of the contract. If found to be non-compliant, the Pennsylvania Turnpike Commission (the "Commission") may purchase the required insurance coverage(s) and the cost will be borne by the Contractor through direct payment/reimbursement to the Commission or the Commission may withhold payment to the Contractor for amounts owed to them.

a) All insurance shall be procured from insurers permitted to do business in the State in which the project is taking place and having an A.M. Best Rating of at least "A-, Class VIII".

b) Contractor shall not have a Self Insured Retention (SIR) on any policy greater than $50,000, which is the responsibility of the Contractor. If Contractor's policy(ies) has a Self Insured Retention exceeding this amount, approval must be received from the Commission prior to starting work. In the event any policy includes an SIR, the Contractor is responsible for payment within the SIR of their policy(ies) and the Additional Insured requirements specified herein shall be offered within the SIR amount(s).

c) All insurance required herein, with the exception of the Professional Liability Insurance, shall be written on an "occurrence" basis. Claims-Made coverage must include:

    i. The retroactive date must be on or prior to the start of work under this contract; and
    ii. The Contractor must purchase "tail coverage/an extended reporting period" or maintain coverage for a period of three years, subsequent to the completion of their work / final payment.

d) The Contractor's insurance carrier (s) shall agree to provide at least thirty (30) days prior written notice to the Commission in the event coverage is canceled or non-renewed, unless cancellation is for non-payment of premium. In the event of cancellation or non-renewal of coverage(s) for any reason, it is the Contractor's responsibility to replace coverage to comply with the Contract requirements so there is no lapse of coverage for any time period.

    In the event the insurance carriers will not issue or endorse their policy(s) to comply with the above it is the responsibility of the Contractor to report any notice of cancellation or non-renewal at least thirty (30) days prior to the effective date of this notice.

e) Contractor shall provide the Commission with Certificates of Insurance, evidencing the insurance coverages listed below, ten days prior to the start of work of this Project and thereafter upon renewal or replacement of each coverage. The Contractor shall not begin any work until the Commission has reviewed and approved the Certificate of Insurance. The required insurance shall not contain any exclusions or endorsements, which are not acceptable to the Commission.

Failure of the Commission to demand such certificate or other evidence of full compliance with these insurance requirements or failure of the Commission to identify a deficiency from evidence that is provided shall not be construed as a waiver of Contractor's obligation to maintain such insurance.

f) The Commission, and its Commissioners, officers, employees and agents shall be added as ADDITIONAL INSUREDS on all liability policies (except Workers' Compensation and Professional Liability Policy, where applicable), for ongoing operations and completed operations on a primary noncontributory basis. Coverage should be provided for a period of three years subsequent to the completion of work/final payment.

The Commission reserves the right to require Contractor to name other parties as additional insureds as required by the Commission.

g) Waiver of Rights of Subrogation: Contractor shall waive all rights of recovery against the Commission and all the additional insureds for loss or damage covered by any of the insurance maintained by the Contractor.

h) The amount of insurance provided in the aforementioned insurance coverages, shall not be construed to be a limitation of the liability on the part of the Contractor.

i) The carrying of insurance described shall in no way be interpreted as relieving the Contractor of any responsibility or liability under the contract.

j) Any type of insurance or any increase in limits of liability not described above which the Contractor requires for its own protection or on account of statute shall be its own responsibility and at its own expense.

k) Contractor shall promptly notify the Commission and the appropriate insurance company(ies) in writing of any accident(s) as well as any claim, suit or process received by the insured Contractor arising in the course of operations under the contract. The Contractor shall forward such documents received to his insurance company(ies), as soon as practicable, or as required by its insurance policy(ies).

REQUIRED COVERAGES - the following may be provided through a combination of primary and excess policies in order to meet the minimum limits set forth below:

1. **Workers' Compensation and Employer's Liability:**
Provided in the State in which the work is to be performed and elsewhere as may be required and shall include:

a) Workers' Compensation Coverage: Statutory Requirements

b) Employers Liability Limits not less than:

Bodily Injury by Accident:	$500,000 Each Accident
Bodily Injury by Disease:	$500,000 Each Employee
Bodily Injury by Disease:	$500,000 Policy Limit

c) Includes sole proprietorships and officers of corporation who will be performing the work.

d) Where applicable, if the Contractor is lending or leasing its employees to the Commission for the work under this contract, it is the Contractor's responsibility to provide the Workers Compensation and Employer's Liability coverage and to have their policy endorsed with the proper Alternate Employer Endorsement.

2. **Commercial General Liability:**
Provided on standard ISO forms or an equivalent form including Premises - Operations, Independent Contractors, Products/Completed Operations, Broad Form Property Damage, Contractual Liability, and Personal Injury and Advertising Injury.

a) Occurrence Form with the following limits:

(1)	General Aggregate:	$2,000,000
(2)	Products/Completed Operations Aggregate:	$2,000,000
(3)	Each Occurrence:	$1,000,000
(4)	Personal and Advertising Injury:	$1,000,000

b) Products/Completed Operations Coverage must be maintained for a period of at least three (3) years after final payment / completion of work (including coverage for the Additional Insureds as set forth in these Insurance Requirements).

3. **Automobile Liability:**
a) Coverage to include All Owned, Hired and Non-Owned Vehicles (or "Any Auto"), if you do not have any Owned Vehicles you are still required to maintain coverage for Hired and Non-Owned Vehicles as either a stand alone policy or endorsed onto the Commercial General Liability policy above

b) Per Accident Combined Single Limit $1,000,000

4. **Professional Liability Insurance:**

a) Minimum Limits of Liability

Per Claim Limit:	$2,000,000
Aggregate Limit:	$2,000,000

b) The Definition of "Covered Services" shall include the services required in the scope of this contract.

APPENDIX D – RFP16-10380-7456

Pennsylvania Turnpike Commission
DIVERSE BUSINESS (DB) REQUIREMENTS

Diverse Business Participation. The Commission is committed to Diverse Business (DB) participation on competitive contracting opportunities. Firms or entities that have not previously performed work or provided services to the Commission are encouraged to respond to the solicitations. RFPs may include DB participation as part of the criteria for the evaluation of proposals, and the Commission may consider DB participation as a selection factor.

Minimum Participation Level (MPL). The minimum participation level (MPL) for the inclusion of DBs will be established in the RFP/advertisement as a percentage.

(a) General Requirements. Section 303 of Title 74 of the Pennsylvania Consolidated Statutes, 74 Pa.C.S. § 303, requires proposer on contracts funded pursuant to the provisions of Title 74 (Transportation) and 75 (Vehicle Code) administered and issued by the Commission to make Good Faith Efforts to solicit subonsultants that are Diverse Businesses (DBs) as defined in Section 303. The DB requirements of Section 303 apply to this contract.

Section 303 requires proposers to make Good Faith Efforts, as described below, to solicit subconsultants that are DBs during the proposal process to maximize participation of DBs in competitive contracting opportunities.

The Commission is committed to participation by DBs and will enforce the requirements of Section 303 and this section. Failure to make Good Faith Efforts and demonstrate such Good Faith Efforts in the solicitation of subconsultants may result in the proposer being declared ineligible for the contract.

Proposers shall document and submit to the Commission all Good Faith Efforts, as described in this section, to solicit subconsultants that are DBs during the solicitation process.

Proposers are encouraged to utilize and give consideration to consultants offering to utilize DBs in the selection and award of contracts.

Proposers shall not discriminate on the basis of gender, race, creed or color in the award and performance of contracts in accordance with 62 Pa.C.S. §3701.

Failure to comply with the requirements of Section 303 or this specification may result in the imposition of sanctions as appropriate under section 531 of the Procurement Code, 62 Pa.C.S.§ 531 relating to debarment and suspension.

The Commission's Director of the Office of Diversity and Inclusion, or designee, is designated the Responsible Official who shall supervise the DB program and ensure that the Commission complies with the DB program.

(b) Definitions. The following definitions apply to terms used in this specification:

1. Disadvantaged Business – A business that is owned or controlled by a majority of persons, not limited to members of minority groups, who are subject to racial, social, ethnic prejudice or cultural bias.

2. Diverse Business – A disadvantaged business, minority-owned or women-owned business or service-disabled veteran-owned or veteran-owned small business that has been certified by a third-party certifying organization.

3. Minority-owned Business – A business owned and controlled by a majority of individuals who are African Americans, Hispanic Americans, Native Americans, Asian Americans, Alaskans or Pacific Islanders.

4. Professional Services – An industry of infrequent, technical or unique functions performed by independent contractors or consultants whose occupation is the rendering of the services, including: (1) design professional services as defined in 62 Pa.C.S.§ 901 (relating to definitions); (2) legal services; (3) advertising or public relations services; (4) accounting, auditing or actuarial services; (5) security consultant services; (6) computer and information technology services; and (7) insurance underwriting services.

5. Pro Forma Effort-The act of completing a form or document identifying efforts to solicit DBs for a project in order to satisfy criteria with little or no expectation that the DBs contacted or identified will perform any of the work.

6. Service-Disabled Veteran-Owned Small Business – A business in the United States which is independently owned and controlled by a service-disabled veteran(s), not dominant in its field of operation, and employs 100 or fewer employees.

7. Subconsultant- Any individual, partnership, firm, or corporation entering into a contract with the prime consultant for work under the contract, including those providing professional and other services.

8. Third-party Certifying Organization – An organization that certifies a small business, minority-owned business, women-owned business or veteran-owned small business as a diverse business. The term includes: (1) the National Minority Supplier Development Council; (2) the Women's Business Development Enterprise National Council; (3) the Small Business Administration; (4) The Department of Veteran Affairs; (5) the Pennsylvania Unified Certification Program.

9. Veteran-owned Small Business –A small business owned and controlled by a veteran or veterans.

10. Women-Owned Business – A business owned and controlled by a majority of individuals who are women.

(c) Actions Required by Proposer during the procurement/consultant selection phase

1. Submission Requirements – Consultant Responsiveness.

a. **Minimum Participation Level (MPL) Documentation -** If the documentation submitted with the proposal demonstrates that the proposer has identified DBs sufficient to meet the MPL established for this contract, the proposer will be deemed to have satisfied the DB requirement during this phase. The proposer is required to provide the business name and business address of each DB and supporting documentation that includes proof of certification.

If the consultant's proposal demonstrates the consultant's inability to meet the MPL established for this contract, the proposer shall demonstrate Good Faith Efforts with its proposal. Failure to submit the required documentation demonstrating Good Faith Efforts as further described below with the proposal may result in a rejection of the proposal.

b. If no MPL has been established for this contract, the proposer is required to either provide a statement of intent that it will self-perform 100% of the work for the agreement, or demonstrate Good Faith Efforts to solicit subconsultants that are DBs. In either case documentation shall be provided with the proposal.

Failure to submit the required information identified above with the proposal may result in a rejection of the proposal.

2. Good Faith Effort Requirements: The documentation of Good Faith Efforts must include the business name and business address of each DB considered. Supporting documentation must also include proof of certification and any explanation of Good Faith Efforts the proposer would like the Commission to consider. Any services to be performed by a DB are required to be readily identifiable to the agreement. Good Faith efforts are demonstrated by seeking out DB participation in the project given all relevant circumstances. The Commission requires the proposer to demonstrate more than Pro Forma Efforts. Evidence of Good Faith Efforts includes, but is not limited to:

a. Consultant solicits through all reasonable and available means the interest of all certified DBs with the capacity to perform the scope of work set forth in the agreement.
b. The proposer must provide written notification at least 5 business days before proposals are due to allow the DBs to respond to the solicitation.
c. The proposer must determine with certainty if DBs are interested by taking appropriate steps to follow up initial solicitations.
d. The proposer must make efforts to select portions of the work to be performed by DBs to includes, where appropriate, breaking out contract work into economically feasible units to facilitate DB participation;
e. It is the proposer's responsibility to make a portion of the work available to DBs and, to select those portions of the work, so as to facilitate DB participation.
f. The proposer shall provide evidence of such negotiations that include the names, addresses, and telephone numbers of DBs considered; A description of the information provided regarding the required work and services for the work selected for subconsultants; and evidence as to why additional agreements could not be reached for DBs to perform the work.
g. Proposers cannot reject or withhold solicitation of DBs as being unqualified without sound reasons based on a thorough investigation of their capabilities.
h. The DB's standing within its industry, membership in specific groups, organizations or associations and political or social affiliations (for example union v. non-union employee status) are not legitimate causes for the rejection or non-solicitation of proposals in the proposer's efforts to meet the Good Faith Efforts requirement.
i. Efforts to assist interested DBs in obtaining bonding, lines of credit or insurance.

3. Actions Taken by the Commission. As part of the proposal review process, the Commission will review the submissions to determine whether the proposer has complied with Section 303 and this requirement in the selection of DB subconsultants. The Commission will determine whether the proposer has either met the MPL or provided acceptable documentation as noted above. The Commission reserves the right to contact proposers for clarification during the review and negotiation process.

If the Commission determines that the proposer has failed to either meet the MPL or provide acceptable documentation as noted above, the proposal may be rejected.

(d) Consultant Requirements During Performance of Services.

1. Replacement of a DB Subconsultant. Consultant must continue good faith efforts through completion of the contract. The obligation to make Good Faith Efforts to solicit subconsultants for any type of service extends to additional work required for any service which is identified to be performed by a DB. If at any time during the performance of the work, it becomes necessary to replace or add a subconsultant that is a DB, the consultant, as appropriate, shall immediately notify the Commission and seek approval in writing in accordance with the Agreement of the need to replace the DB, which notice shall include the reasons for the replacement. If a prime consultant who originally indicated that it would self-perform all work subsequently decides to use a subconsultant for any work under the contract, the consultant must submit documentation of all Good Faith Efforts as to the work for which a subconsultant is obtained.

2. Records. Maintain project records as are necessary to evaluate DB compliance and as necessary to perform the reporting function addressed below. Maintain all records for a period of 3 years following acceptance of final payment. Make these records available for inspection by the Commission, its designees or agents. These records should indicate:

2.a. The number of DB and non-DB subconsultants and the type of services performed on or incorporated in this project.

2.b. The progress and efforts made in seeking out DB subconsultant organizations and individual DB consultants for work on this project to increase the amount of DB participation and/or to maintain the commitments made at the time of the proposal to DBs.

2.c. Documentation of all correspondence, contacts, telephone calls, and other contacts made to obtain the service of DBs on this project.

3. Reports. Maintain monthly reports and submit reports as required by the Commission concerning those contracts and other business executed with DBs with respect to the records referred to in subsection (e)2. above in such form and manner as prescribed by the Commission. At a minimum, the Reports shall contain the following:

3.a The number of Contracts with DBs noting the type of services provided, including the execution date of each contract.

3.b The amounts paid to each DB during the month, the dates of payment, and the overall amounts paid to date. If no payments are made to a DB during the month, enter a zero ($0) payment.

3.c Upon request and upon completion of individual DB firm's work, submit paid invoices or a certification attesting to the actual amount paid. In the event the actual amount paid is less than the award amount, a complete explanation of difference is required.

4. Subconsultant Contracts

4.a. Subcontracts with DB firms will not contain provisions waiving legal rights or remedies provided by laws or regulations of the Federal Government or the Commonwealth of Pennsylvania or the Commission through contract provisions or regulations.

4.b. Prime consultant will not impose provisions on DB subconsultants that are more onerous or restrictive than the terms of the prime's contract with non-DBs.

4.c. Executed copies of subcontracts/purchase orders are to be received by the Commission before the commencement of work by the DB.

5. Payments to DB Subconsultants. Payments to DBs are to be made in accordance with the prompt payment requirements of Chapter 39, Subchapter D of the Procurement Code, 62 Pa.C.S. §3931 et seq. Performance of services by a DB subcon sultant in accordance with the terms of the contract entitles the subconsultant to payment.

(e) Actions to be Taken by Commission After Performance of Services. Following completion of the Consultant's services, the Director of the Commission's Office of Diversity and Inclusion or his/her designee will review the overall DB participation to assess the Consultant's compliance with Section 303 and this contract. Appropriate sanctions may be imposed under 62 Pa.C.S. § 531 (relating to debarment or suspension) for a Consultant's failure to comply with Section 303 and the requirements of the contract.

Appendix E
RFP16-10380-7456

AGREEMENT

This **AGREEMENT** is made this _____ day of _____, 2016, between the **Pennsylvania Turnpike Commission ("COMMISSION")**, an instrumentality of the Commonwealth of Pennsylvania, with principal offices at 700 South Eisenhower, Blvd., Middletown, Pennsylvania 17057 (mailing address: P. O. Box 67676, Harrisburg, PA 17106-7676);

AND

_____ ("CONTRACTOR"), **[insert the legal status of CONTRACTOR such as a Pennsylvania (or Foreign) corporation (or partnership, LLC, LLP, etc)]**, with its principal office at **[insert address].**

WITNESSETH:

WHEREAS, the **COMMISSION** desires **[insert service to be provided];**

WHEREAS, by Act No. 211 of the General Assembly of the Commonwealth of Pennsylvania, approved May 21, 1937, and its amendments, the **COMMISSION** is authorized and empowered to enter into an Agreement with the **CONTRACTOR**;

WHEREAS, the **COMMISSION** desires to retain the services of **CONTRACTOR** upon the following terms; and

NOW, THEREFORE, in consideration of these mutual covenants, and intending to be legally bound, the parties agree as follows:

Contractor's Scope of Work

[There should be a document that specifies what we expect from the Contractor (such as deliverables; schedules and deadlines; representations or warranties; conditions or covenants; location of the work; use of specific persons; standards of performance; insurance requirements). This document must be made part of the Agreement (either as an exhibit which is attached or by referring to it in the Agreement without attaching it)].

The **CONTRACTOR** will perform the work described in **[identify the document/RFP#]** dated **[date]**, titled [**title]** and the **CONTRACTOR'S** proposal dated **[date]**. This document is **[SELECT ONE**: attached as Exhibit_ and made a part of this Agreement **OR** made part of this Agreement by reference].

Compensation

For the work, services, and material as defined in this Agreement, the **CONTRACTOR** shall be paid **[insert Commission approved compensation].**

The **CONTRACTOR** agrees that the **COMMISSION** may set off the amount of any state tax liability or other obligation of the **CONTRACTOR** or its subsidiaries to the Commonwealth against any payments due the **CONTRACTOR** under any contract with the **COMMISSION**.

Duration of Agreement and Renewal

The term of this Agreement shall be for a period of one year and shall commence on the Effective Date as defined below or after implementation with benefit vendor(s) whichever occurs later. If the Commission utilizes the continuation of services option it would be for up to four (4), one (1) year renewal options.

The Effective Date shall be fixed by the **COMMISSION** after the Agreement has been fully executed by the **CONTRACTOR** and by the **COMMISSION**, and after all approvals required by the **COMMISSION** contracting procedures have been obtained.

This Agreement will not terminate until the **COMMISSION** accepts all work as complete and tenders final payment to the **CONTRACTOR**.

Termination

Either party may terminate this Agreement at any time upon thirty- (30) calendar days written notice. If this notice is given, the **CONTRACTOR** shall be paid only for the services already rendered upon the date of the notice and for the services rendered to the date of termination, subject to all provisions of this Agreement. The notice will be effective on the date of receipt. The right to cancel may be exercised as to the entire project, or as to any particular phase or phases, part or parts, and upon one or upon several occasions, but any termination may not be revoked except upon written consent of the parties through a supplemental Agreement to this Agreement.

Insurance

The **CONTRACTOR**, prior to execution of this Agreement, shall furnish to the **COMMISSION** the certificates of insurances as required in attached **Exhibit "X"** and made a part of this Agreement.

Diverse Business (DB) Requirements

The **CONTRACTOR** agrees to comply with the requirements set forth in the **COMMISSION'S** DB Requirements **- Exhibit X**, attached and made part of this Agreement. In particular, the **CONTRACTOR** agrees to comply with section (d) Consultant Requirements During Performance of Services.

Assignment and Delegation

The **CONTRACTOR** may not transfer, assign, or delegate any terms of this Agreement, in whole or in part, without prior written permission from the **COMMISSION**.

Governing Law

This Agreement will be interpreted according to the laws of the Commonwealth of Pennsylvania.

Observance of Laws

The **CONTRACTOR** agrees to observe all relevant federal, state, and local laws and to obtain in its name all necessary permits and licenses.

Work for Hire

Except for hardware, third party licensed software, and software previously developed by **CONTRACTOR,** all Deliverables, including but not limited to source code, software, specifications, plans, designs and engineering, drawings, data, information or other written, recorded, photographic, or visual materials, trademarks, service marks, copyrights or other Deliverables produced by **CONTRACTOR** or any supplier in the performance of this Agreement shall be deemed "Work Product". All Work Product shall be considered services for hire. Accordingly, except as set forth earlier in this paragraph, all Work Product shall be the exclusive property of the **COMMISSION**.

The **CONTRACTOR** agrees to notify the **COMMISSION** in writing before using any of **CONTRACTOR's** previously developed software for services provided under this Agreement.

The **CONTRACTOR** and the **COMMISSION** will honor all applicable preexisting licenses, copyrights, trademarks, service marks, and patents. If as part of an expense item under this Agreement, the **CONTRACTOR** purchases the right to any license, the agreements for the use or ownership of such license will be placed in the name of the **COMMISSION** along with all other rights and obligations. In addition, the **CONTRACTOR** will mark all Turnpike content or previously unprotected work product designated by the **COMMISSION** with a notice as follows: "Pennsylvania Turnpike Commission, (Year)".

Audit/Retention of Records

CONTRACTOR and its subcontractors shall maintain books and records related to performance of this Agreement or subcontract and necessary to support amounts charged to the **COMMISSION** in accordance with applicable law, terms and conditions of this Agreement, and generally accepted accounting practice. **CONTRACTOR** shall maintain these books and records for a minimum of three (3) years after the completion of the Agreement, final payment, or completion of any contract, audit or litigation, whichever is later. All books and records shall be available for review or audit by the **COMMISSION,** its representatives, and other governmental entities with monitoring authority upon reasonable notice and during normal business hours. **CONTRACTOR** agrees to cooperate fully with any such review or audit. If any audit indicates overpayment to **CONTRACTOR,** or subcontractor, the **COMMISSION** shall adjust future or final payments otherwise due. If no payments are due and owing to **CONTRACTOR,** or if the overpayment exceeds the amount otherwise due, **CONTRACTOR** shall immediately refund all amounts which may be due to the **COMMISSION.** Failure to maintain the books and records required by this Section shall establish a presumption in favor of the **COMMISSION** for the recovery of any funds paid by the **COMMISSION** under this Agreement for which adequate books and records are not available to support the purported disbursement.

Dispute Resolution

All questions or disputes regarding any matter involving this Agreement or its breach shall be referred to the Board of Claims of the Commonwealth of Pennsylvania pursuant to 62 Pa.C.S.A.

§ 1701 *et seq*. If the Board of Claims either refuses or lacks jurisdiction, these questions or disputes shall proceed as provided in 42 Pa.C.S.A. § 7301 *et seq*. (Statutory Arbitration).

The panel of arbitrators will consist of a representative of each of the parties and a third party chosen by the representatives, or if the representatives are unable to choose, by the American Arbitration Association.

Indemnification

The **CONTRACTOR** shall be responsible for, and shall indemnify, defend, and hold harmless the **COMMISSION** and its Commissioners, officers, employees, and agents (the "Indemnified Parties") from all claims, liabilities, damages, and costs including reasonable attorneys' fees, for bodily injury (including death) and damage to real or tangible personal property arising from or related to the negligence or other tortious acts, errors, and omissions of **CONTRACTOR**, its employees, or its subcontractors while engaged in performing the work of this Agreement or while present on the **COMMISSION's** premises, and for breach of this Agreement regarding the use or nondisclosure of proprietary and confidential information where it is determined that **CONTRACTOR** is responsible for any use of such information not permitted by this Agreement. This indemnification obligation shall not be reduced in any way by any limitation on the amount or type of damages, compensation, or benefits payable by **CONTRACTOR** or its subcontractors under any employee benefit act including but not limited to Workers' Compensation Acts, Disability Benefits Acts, or other Employee Benefit Act.

Contractor Integrity Provisions

The Contractor Integrity Provisions are attached as **[Exhibit X]** and made a part of this Agreement.

Confidentiality Provisions

1. As a consequence of the performance of its duties with the **COMMISSION**, **CONTRACTOR** may learn, be given, or become aware of certain information, including, but not limited to, matters pertaining to internal communications, information, proprietary information, individually identifiable health information, trade practices, business operations, or other sensitive information collectively known as Confidential Information. Regardless of how transmitted or received by **CONTRACTOR**, whether by receipt, sending, or merely becoming available to **CONTRACTOR** through its relationship to the **COMMISSION**, **CONTRACTOR** agrees to maintain and treat as proprietary and confidential to the **COMMISSION** all such Commission Confidential Information, and shall not discuss, reveal, or use for any purpose outside the performance of its contract with the **COMMISSION** such Commission Confidential Information. Confidential Information shall not include any information that (i) is or becomes available to the public other than as a consequence of a breach by any individual, a partnership, a corporation, an association, a limited liability company, a joint stock company, a trust, a joint venture, an unincorporated organization (each a "Person") of any fiduciary duty or obligation of confidentiality, including, without limitation, catalogues, publications, product descriptions and sales literature that the COMMISSION has distributed to the public generally; or (ii) information which at the time of disclosure to the CONTRACTOR is in the public domain; or (iii) is disclosed as required by a final, unappealable court order and no suitable protective order, or equivalent remedy, is available, or (iv) the CONTRACTOR was aware of prior to its disclosure to the CONTRACTOR by the COMMISSION from a source not bound by a confidential

obligation and the CONTRACTOR provides the COMMISSION written notice of such fact prior to the execution of this Agreement or promptly upon the CONTRACTOR's learning that the information was Confidential Information; or (v) information which the CONTRACTOR can demonstrate with competent written evidence was independently developed by or for the CONTRACTOR without use of or reliance on the Confidential Information.

2. With respect to its employees, **CONTRACTOR** agrees

a) to require all of its employees to maintain confidentiality;

b) to prosecute its employees, officers, and subcontractors for any and all violations of this Agreement;

c) to keep such agreements in full force and effect;

d) to obtain from the **COMMISSION** its approval, which shall not be unreasonably withheld, of the terms of such agreements; and

e) to permit the **COMMISSION** to inspect such agreements and other documents for compliance with these requirements.

3. With respect to any subcontractors that **CONTRACTOR** wishes to employ to perform any of its obligations under any agreement with the **COMMISSION**, **CONTRACTOR** agrees to require any such approved subcontractor to execute written confidentiality agreements that require each such **CONTRACTOR** and its employees to comply with all the requirements set forth above.

4. **CONTRACTOR** agrees that any breach of these Confidentiality Provisions may result in civil and/or criminal penalties, for **CONTRACTOR**, its officers and employees, and subcontractors.

5. Notwithstanding any other provision to the contrary, **CONTRACTOR** agrees that these provisions shall survive the termination of this and any and all agreements between the **CONTRACTOR** and the **COMMISSION**.

6. **CONTRACTOR** agrees to treat the information in the same way **CONTRACTOR** treats its own most confidential information and to inform each such person of these provisions.

7. **CONTRACTOR** agrees to immediately notify the **COMMISSION** of any information which comes to its attention which does or might indicate that there has been any loss of confidentiality or information.

8. **CONTRACTOR** shall return to the **COMMISSION** upon demand any and all Confidential Information entrusted to it by the **COMMISSION** pursuant to this Agreement (including any and all copies, abstracts, compilations or analyses thereof and memoranda related thereto or incorporating the Confidential Information) or the **CONTRACTOR** may request permission from the **COMMISSION**, which permission may be granted or denied in the **COMMISSION**'s sole discretion, to destroy all such Confidential Information and provide a certificate of destruction to the **COMMISSION** signed by the **CONTRACTOR**. The **CONTRACTOR**

further agrees that neither itself nor its employees or representatives will copy, in whole or in part, any such Confidential Information without the prior written consent of the **COMMISSION**.

9. **CONTRACTOR** agrees that if they have had or will have an SSAE16 audit that they will comply with and abide by the findings of such audit to protect **COMMISSION** information.

Entire Agreement

This Agreement, together with any writings either attached as exhibits or incorporated by reference, constitutes the entire understanding between the parties and there are no other oral or extrinsic understandings of any kind between the parties.

Modification

This Agreement may be modified only by a writing signed by both parties.

[SIGNATURES ARE SET FORTH ON THE NEXT PAGE]

IN WITNESS WHEREOF, the **Pennsylvania Turnpike Commission** and **[Contractor's Name]** have executed this Agreement by their duly authorized officers on the date written above.

ATTEST: PENNSYLVANIA TURNPIKE COMMISSION

_____	_____	_____	_____
Ann Louise Edmunds Assistant Secretary-Treasurer	Date	Sean Logan Chairman	Date

APPROVED AS TO FORM AND LEGALITY:

_____	_____	_____	_____
Albert C. Peters II General Litigation & Contracts Counsel	Date	Pennsylvania Attorney General	Date

ATTEST: **[CONTRACTOR'S NAME]**

Signature_____	_____	Signature_____	_____
	Date		Date
Name_____		Name_____	
Title_____		Title_____	

Federal Tax ID No._____

CONTRACTOR INTEGRITY PROVISIONS

It is essential that those who seek to contract with the Pennsylvania Turnpike Commission ("Commission") observe high standards of honesty and integrity. They must conduct themselves in a manner that fosters public confidence in the integrity of the Commission contracting and procurement process.

I. DEFINITIONS. For purposes of these Contractor Integrity Provisions, the following terms shall have the meanings found in this Section:

a. **"Affiliate"** means two or more entities where (a) a parent entity owns more than fifty percent of the voting stock of each of the entities; or (b) a common shareholder or group of shareholders owns more than fifty percent of the voting stock of each of the entities; or (c) the entities have a common proprietor or general partner.

b. **"Consent"** means written permission signed by a duly authorized officer or employee of the Commission, provided that where the material facts have been disclosed, in writing, by prequalification, bid, proposal, or contractual terms, the Commission shall be deemed to have consented by virtue of the execution of this contract.

c. **"Contractor"** means the individual or entity, that has entered into this contract with the Commission, and "Contractor Related Parties" means any affiliates of the Contractor and the Contractor's executive officers, Pennsylvania officers and directors, or owners of 5% or more interest in the Contractor

d. **"Financial Interest"** means either:

i. Ownership of more than a five percent interest in any business; or

ii. Holding a position as an officer, director, trustee, partner, employee, or holding any position of management.

e. **"Gratuity"** means tendering, giving, or providing anything of monetary value including, but not limited to, cash, travel, entertainment, gifts, meals, lodging, loans, subscriptions, advances, deposits of money, services, employment, or contracts of any kind. See Commission Policy 3.10, Code of Conduct.

f. **"Non-bid Basis"** means a contract awarded or executed by the Commission with Contractor without seeking bids or proposals from any other potential bidder or offeror.

II. In furtherance of this policy, Contractor agrees to the following:

1. Contractor shall maintain the highest standards of honesty and integrity during the performance of this contract and shall take no action in violation of state or federal laws or regulations or any other applicable laws or regulations, or other requirements applicable to Contractor or that govern contracting or procurement with the Commission.

2. Contractor shall establish and implement a written business integrity policy, which includes, at a minimum, the requirements of these provisions as they relate to Contractor activity with the Commission and Commission employees and which is made known to all Contractor employees. Posting these Contractor Integrity Provisions conspicuously in easily-accessible and well-lighted places customarily frequented by employees and at or near where the contract services are performed shall satisfy this requirement.

3. Contractor, its affiliates, agents, employees and anyone in privity with Contractor shall not accept, agree to give, offer, confer, or agree to confer or promise to confer, directly or indirectly, any gratuity or pecuniary benefit to any person, or to influence or attempt to influence any person in violation of the Public Official and Employees Ethics Act, 65 Pa.C.S. §§1101 et seq.; the State Adverse Interest Act, 71 P.S. §776.1 et seq.; Commission Policy 3.10, Code of Conduct or in violation of any other federal or state law in connection with performance of work under this contract, except as provided in this contract.

4. Contractor shall not have a financial interest in any other contractor, subcontractor, or supplier providing services, labor, or material under this contract, unless the financial interest is disclosed to the Commission in writing and the Commission consents to Contractor's financial interest prior to Commission execution of the contract. Contractor shall disclose the financial interest to the Commission at the time of bid or proposal submission, or if no bids or proposals are solicited, no later than Contractor's submission of the contract signed by Contractor.

5. Contractor certifies to the best of its knowledge and belief that within the last five (5) years Contractor or Contractor Related Entities have not:

a. been indicted or convicted of a crime involving moral turpitude or business honesty or integrity in any jurisdiction;

b. been suspended, debarred or otherwise disqualified from entering into any contract with any governmental agency;

c. had any business license or professional license suspended or revoked;

d. had any sanction or finding of fact imposed as a result of a judicial or administrative proceeding related to fraud, extortion, bribery, bid rigging, embezzlement, misrepresentation or anti-trust; and

e. been, and is not currently, the subject of a criminal investigation by any federal, state or local prosecuting or investigative agency and/or civil anti-trust investigation by any federal, state or local prosecuting or investigative agency.

If Contractor cannot so certify to the above, then it must submit along with its bid, proposal or contract a written explanation of why such certification cannot be made and the Commission will determine whether a contract may be entered into with the Contractor. The Contractor's obligation pursuant to this certification is ongoing from and after the effective date of the contract through the termination date thereof. Accordingly,

the Contractor shall have an obligation to immediately notify the Commission in writing if at any time during the term of the contract if becomes aware of any event which would cause the Contractor's certification or explanation to change. Contractor acknowledges that the Commission may, in its sole discretion, terminate the contract for cause if it learns that any of the certifications made herein are currently false due to intervening factual circumstances or were false or should have been known to be false when entering into the contract.

6. Contractor shall comply with the requirements of the Lobbying Disclosure Act (65 Pa.C.S. §13A01 et seq.) regardless of the method of award. If this contract was awarded on a Non-bid Basis, Contractor must also comply with the requirements of the Section 1641 of the Pennsylvania Election Code (25 P.S. §3260a).

7. When Contractor has reason to believe that any breach of ethical standards as set forth in law, Commission Policy 3.10, Code of Conduct, or these Contractor Integrity Provisions has occurred or may occur, including but not limited to contact by a Commission officer or employee which, if acted upon, would violate such ethical standards, Contractor shall immediately notify the Commission contracting officer or the Chief Compliance Officer in writing.

8. Contractor, by submission of its bid or proposal and/or execution of this contract and by the submission of any bills, invoices or requests for payment pursuant to the contract, certifies and represents that it has not violated any of these Contractor Integrity Provisions in connection with the submission of the bid or proposal, during any contract negotiations or during the term of the contract, to include any extensions thereof. Contractor shall immediately notify the Commission in writing of any actions for occurrences that would result in a violation of these Contractor Integrity Provisions. Contractor agrees to reimburse the Commission for the reasonable costs of investigation incurred by the Chief Compliance Officer for investigations of the Contractor's compliance with the terms of this or any other agreement between the Contractor and the Commission that results in the suspension or debarment of the Contractor. Contractor shall not be responsible for investigative costs for investigations that do not result in the Contractor's suspension or debarment.

9. Contractor shall cooperate with the Chief Compliance Officer in investigating any alleged Commission agency or employee breach of ethical standards and any alleged Contractor non-compliance with these Contractor Integrity Provisions. Contractor agrees to make identified Contractor employees available for interviews at reasonable times and places. Contractor, upon the inquiry or request of the Chief Compliance Officer, shall provide, or if appropriate, make promptly available for inspection or copying, any information of any type or form deemed relevant by the Chief Compliance Officer to Contractor's integrity and compliance with these provisions. Such information may include, but shall not be limited to, Contractor's business or financial records, documents or files of any type or form that refer to or concern this contract. Contractor shall incorporate this paragraph in any agreement, contract or subcontract it enters into in the course of the performance of this contract/agreement solely for the purpose of obtaining subcontractor compliance with this provision. The incorporation of this provision in a subcontract shall not create privity of contract between the Commission and any such subcontractor, and no third party beneficiaries shall be created thereby.

10. For violation of any of these Contractor Integrity Provisions, the Commission may terminate this and any other contract with Contractor, claim liquidated damages in an amount equal to the value of anything received in breach of these Provisions, claim damages for all additional costs and expenses incurred in obtaining another contractor to complete performance under this contract, and debar and suspend Contractor from doing business with the Commonwealth. These rights and remedies are cumulative, and the use or non-use of any one shall not preclude the use of all or any other. These rights and remedies are in addition to those the Commission may have under law, statute, regulation, or otherwise.

PENNSYLVANIA TURNPIKE COMMISSION
BUSINESS ASSOCIATE AMENDMENT

Health Insurance Portability and Accountability Act (HIPAA) Compliance

This Amendment made this _____ day of _____, 2016, between the **Pennsylvania Turnpike Commission** and _____, contains additions to the terms and conditions of the Agreement dated _____ between the parties hereto.

WHEREAS, the **Pennsylvania Turnpike Commission** (hereinafter the "Covered Entity") will make available and/or transfer to _____ (hereinafter the "Business Associate") certain Protected Health Information (PHI), in conjunction with goods or services that are being provided by Business Associate to or on behalf of the Pennsylvania Turnpike Commission, that is confidential and must be afforded special treatment and protection in accordance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Regulations at 45 CFR Part 160-164.

WHEREAS, Business Associate will have access to and/or receive from Covered Entity, PHI that can be used or disclosed only in accordance with this Amendment and the HIPAA Privacy Regulations at 45 CFR Part 160-164.

NOW, THEREFORE, Covered Entity and Business Associate agree as follows:

1. Definitions.

a. "Business Associate" shall have the meaning given to such term under the HIPAA Regulations, including but not limited to, 45 CFR § 160.103.

b. "Covered Entity" shall have the meaning given to such term under HIPAA and the HIPAA Privacy Regulations, including, but not limited to, 45 CFR § 160.103.

c. "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium; (i) that relates to the past, present or future physical or mental condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual, and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under HIPAA and the HIPAA Privacy Regulations, including, but not limited to 45 CFR § 164.501.

d. In accordance with 45 CFR Part 160-164, the Pennsylvania Turnpike Commission is the **Covered Entity** and _____ is the **Business Associate**.

e. Terms used, but not otherwise defined in this Agreement shall have the same meaning as those terms in 45 CFR Parts 160-164.

2. Limits on Use and Disclosure Established by Terms of Amendment. Business Associate hereby agrees that it shall be prohibited from using or disclosing the PHI provided or made available by Covered Entity for any purpose other than as expressly permitted or required by this Amendment, in accordance with 45 CFR § 164.504(e)(2)(i).

3. Stated Purposes for which Business Associate May use or Disclose PHI. The Parties hereby agree that Business Associate shall be permitted to use and/or disclose PHI provided or made available from Covered Entity for the following stated purposes: _____.

4. Additional Purposes for which Business Associate May use or Disclose Information. In addition to the stated purposes, Business Associate may use or disclose PHI provided or made available from Covered Entity for the following additional purpose(s):

a. **Use of Information for Management, Administration and Legal Responsibilities.** Business Associate is permitted to use PHI if necessary for the proper management and administration of Business Associate or to carry out legal responsibilities of the Business Associate. 45 CFR § 164.504(e)(4)(ii).

b. **Disclosure of Information for Management, Administration and Legal Responsibilities.** Business Associated is permitted to disclose PHI received from Covered Entity for the proper management and administration of Business Associate or to carry out legal responsibilities of Business Associated, provided that:

i) The disclosure is required by law; or
ii) The Business Associate obtains reasonable assurances in writing 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 purposes for which it was disclosed to the person, the person will use appropriate safeguards to prevent use or disclosure of the information, and the person immediately notifies the Business Associate of any instance of which it is aware in which the confidentiality of the information has been breached. 45 CFR § 164.504(e)(4)(ii).

c. **Data Aggregation Services.** Business Associate is also permitted to use or disclose PHI to provide data aggregation services, as that term is defined by 45 CFR § 164.501, relating to healthcare operations of Covered Entity. 45 CFR § 164.504(e)(2)(i)(B).

5. BUSINESS ASSOCIATE OBLIGATIONS:

a. **Limits on Use and Further Disclosure Established by Amendment and Law.** Business Associate hereby agrees that the PHI provided or made available by Covered Entity shall not be further used or disclosed other than as permitted or required by the Amendment or as required by law. 45 CFR § 165.404(e)(2)(ii)(A).

b. **Appropriate Safeguards.** Business Associate will establish and maintain appropriate safeguards to prevent any use or disclosure of PHI other than as provided for by this Amendment. 45 CFR § 164.504(e)(2)(ii)(B).

c. **Reports of Improper Use or Disclosure.** Business Associate hereby agrees that it shall report to Judy K. Treaster, Manager, Compensation and Benefits in Covered Entity's Human Resources Department, within two (2) days of discovery of any use or disclosure of PHI not provided for or allowed by this Amendment. 45 CFR § 164.504(e)(2)(ii)(C).

d. **Subcontractors and Agents.** Business Associate hereby agrees that anytime PHI is provided or made available to any subcontractors or agents, Business Associate shall provide only the minimum necessary PHI for the purpose of the covered transaction and must enter into a subcontract or contract with the subcontractor or agent that contains the same terms, conditions and restrictions on the use and disclosure of PHI as contained in this Amendment. 45 CFR § 164.504(e)(2)(ii)(D).

e. **Right of Access to PHI.** Business Associate hereby agrees to make available to an individual who is the subject of the PHI the right to access and copy that individual's PHI, at the request of the individual or of the Covered Entity, in the time and manner designated by the Covered Entity. This right of access shall conform with and meet all the requirements of 45 CFR § 164.524 and 45 CFR § 164.504(e)(2)(ii)(E).

f. **Amendment and Incorporation of Amendments**. Business agent agrees to make any amendments to PHI that have been agreed to by the Covered Entity, at the request of Covered Entity or of the individual in the time and manner designated by Covered Entity, in accordance with 45 CFR 164.526 and 45 CFR § 164.504(e)(2)(ii)(F).

g. **Provide Accounting.** Business Associate agrees to document and make available to Covered Entity or to the individual any information necessary to provide an accounting of disclosures in accordance with 45 CFR § 164.528 and 45 CFR § 164.504(e)(2)(ii)(G), within 30 days of receipt of a request for an accounting, in the manner designated by the Covered Entity.

h. **Access to Books and Records.** Business Associate hereby agrees to make its internal practices, books and records relating to the use or disclosure of PHI received from, or created or received by Business Associate on behalf of the Covered Entity, available to the Secretary of Health and Human Services or designee for purposes of determining compliance with the HIPAA Privacy Regulations. 45 CFR § 164.504(e)(2)(ii)(H).

i. **Return or Destruction of PHI.** At termination of this Amendment, Business Associate hereby agrees to return or destroy all PHI received from or created or received by Business Associate on behalf of Covered Entity. Business Associate agrees not to retain any copies of the PHI after termination of this Amendment. If return or destruction of the PHI is not feasible, business Agent agrees to such time as the PHI may be returned or destroyed. If Business Associate elects to destroy the PHI, it shall certify to Covered Entity that the PHI has been destroyed. 45 CFR § 164.504(e)(2)(ii)(I).

j. **Mitigation Procedures.** Business Associate agrees to establish and to provide to the Pennsylvania Turnpike Commission upon request, procedures for mitigating to the maximum extent practicable, any harmful effect from the use or disclosure of PHI in a manner contrary to this Amendment or the HIPAA Privacy Regulations. 45 CFR § 164.530(f). Business Associate further agrees to mitigate any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of this Amendment.

k. **Sanction Procedures.** Business Associate agrees that it must develop and implement a system of sanctions for any employee, subcontractor or agent who violates this Amendment or the HIPAA Privacy Regulations. 45 CFR § 164.530(e)(1).

l. **Grounds for Breach.** Any noncompliance by Business Associate with this Amendment or the HIPAA Privacy Regulations will automatically be considered to be grounds for breach pursuant to the underlying agreement, if Business Associate knew or reasonably should have known of such noncompliance and failed to immediately take responsible steps to cure the noncompliance.

m. **Termination by Covered Entity.** Notwithstanding the termination language in the underlying contract, Business Associate authorizes termination of the underlying contract by the Covered Entity if the Covered Entity determines, in its sole discretion, that the Business Associate has violated a material term of this Amendment.

n. **Privacy Practices.** The Covered Entity shall provide and Business Associate shall immediately begin using any form, including but not limited to, used for Consent, Notice of Privacy Practices, Accounting for Disclosures or Authorization, designated as effective by the Covered Entity at any given time. The Covered Entity retains the right to change the applicable privacy practices and documents. The Business Associate must implement changes as soon as practicable, but not later than 45 days from the date of notice of the change.

6. **OBLIGATIONS OF COVERED ENTITY:**

a. **Provision of Notice of Privacy Practices.** Covered Entity shall provide Business Associate with the notice of privacy practices that the Covered Entity produces in accordance with 45 CFR § 164.520, as well as changes to such notice.

b. **Permissions.** Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by individual to use or disclose PHI, if such change affects Business Associate's permitted or required uses and disclosures.

c. **Restrictions.** Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that the Covered Entity has agreed to in accordance with 45 CFR § 164.522.

[SIGNATURES ARE SET FORTH ON THE NEXT PAGE]

IN WITNESS WHEREOF, the **Pennsylvania Turnpike Commission** and _____] have executed this Agreement by their duly authorized officers on the date written above.

ATTEST: PENNSYLVANIA TURNPIKE COMMISSION

_____ _____ _____ _____
Ann Louise Edmunds Date Sean Logan Date
Assistant Secretary-Treasurer Chairman

APPROVED AS TO FORM AND LEGALITY:

_____ _____ _____ _____
Albert C. Peters II Date Pennsylvania Attorney General Date
General Litigation & Contracts Counsel

ATTEST: [COMPANY'S NAME]

Signature_____ _____ Signature_____ _____
Date Date
Name_____ Name_____

Title_____ Title_____

Federal Tax ID No. _____

Cost Proposal
(Fixed fee or hourly rates)

The total cost you are proposing must be broken down but not limited to the following components. Any costs not provided in the cost proposal will be assumed at no charge to the Commission.

Vendor Selection and Contract Implementation	Vendor Response
Estimate labor hours based on IV-4A	
Total cost for each personnel with a different rate per hour and for all labor costs	
Subcontractor Costs	
Transportation*	
Lodging	
Meals	
Cost of Supplies and Materials (itemize)	
OVERALL COST	
MUST PROVIDE A MAXIMUM DOLLAR AMOUNT THAT WILL NOT BE EXCEEDED.	

CONTINUATION OF SERVICES	Vendor Response
Estimate labor hours based on IV-4B	
Total cost for each personnel with a different rate per hour and for all labor costs	
Subcontractor Costs	
Transportation*	
Lodging	
Meals	
Cost of Supplies and Materials (itemize)	
TOTAL COST	
MAXIUMUM MONTHLY COST	
TOTAL FIXED MONTHLY FEE COST	

* Travel and subsistence costs must not exceed current CONUS rates and IRS approved mileage rates

Appendix H - Health Benefit Summaries
RFP#16-10380-7456

Benefits	Network	Out-of-Network
Benefit Period	Calendar Year	
Deductible (per benefit period) Individual Family *(Aggregate)*	 None None	 $400 $800
Plan Payment Level - Based on the plan allowance	100%	70% after deductible, until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits Includes coinsurance. See the section "How Your Benefits Are Applied" for exclusions/details	None	$1,500 Individual Individual $3,000 Family (Aggregate)
Lifetime Maximum (per member)	Unlimited	
Ambulance Service	100%	70% after deductible
Anesthesia for Non-Covered Dental Procedures (Limited)	100%	70% after deductible
Assisted Fertilization Treatment	Not Covered	
Dental Services Related to Accidental Injury	100%	70% after deductible
Diabetes Treatment	100%	70% after deductible
Diagnostic Services *Advanced Imaging (*MRI, CAT Scan, PET scan, etc.)	100%	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	70% after deductible
Emergency Room Services Facility Services	100% after $50 Copay; Observation care for multiple dates of service for the same claim, a $50 Copay will apply for each 3 floating day period (waived if admitted as an inpatient)	
Enteral Formulae	100%	70%; deductible does not apply
Hearing Care Services	100% Combined Limit: $350 allowance per 36 month period (hearing aid must be purchased within 6 months of evaluation)	
Home Health Care[1] Excludes Respite Care	100% Combined Limit: 90 visits per benefit period	70% after deductible
Home Infusion and Suite Infusion Therapy Services	100%	70% after deductible
Hospice Care Includes Respite Care	100%	70% after deductible

Benefits	Network	Out-of-Network
Hospital Services Inpatient[2] and Outpatient[2 3]	100%	70% after deductible
Infertility Counseling, Testing and Treatment[4]	100%	70% after deductible
Maternity (non-preventive facility and professional services) Includes Dependent Daughters	100%	70% after deductible
Medical Care Includes Inpatient Visits and Consultations	100%	70% after deductible
Mental Health Services - Inpatient	100%	70% after deductible
Mental Health Services - Outpatient	100% after $25 Copay	70% after deductible
Office Visits Primary Care Physician	100% after $15 Copay	70% after deductible
Specialty Care Physician	100% after $25 Copay	70% after deductible
Urgent Care Center	100% after $25 Copay	70% after deductible
Oral Surgery	100%	70% after deductible
Physical Medicine Outpatient	100% after $25 Copay	70% after deductible
	Combined Limit: 20 visits per benefit period	
Preventive Care[5]		
Adult Routine Physical Exams	100% after $15 Copay	70% after deductible
Adult Immunizations	100%	70% after deductible
Colorectal Cancer Screening	100%	70% after deductible
Diagnostic Services and Procedures	100%	70% after deductible
Mammograms, annual routine and medically necessary	100%	70% after deductible
Routine gynecological exams, including a PAP Test	100% after $25 Copay	70%; deductible does not apply
Pediatric		
Routine Physical Exams	100% after $15 Copay	70% after deductible
Pediatric Immunizations	100%	70%; deductible does not apply
Diagnostic Services and Procedures	100%	70% after deductible
Private Duty Nursing	100%	70% after deductible
	Combined Limit: 240 hours maximum per benefit period	
Skilled Nursing Facility Care	100%	70% after deductible
	Combined Limit: 100 days per benefit period	
Speech & Occupational Therapy Outpatient	100% after $25 Copay	70% after deductible
	Combined Limit: 12 visits per benefit period/per type of therapy	

Benefits	Network	Out-of-Network
Spinal Manipulations	100% after $25 Copay	70% after deductible
	Combined Limit: 20 visits per benefit period	
Substance Abuse Services - Detoxification	100%	70% after deductible
Substance Abuse Services - Inpatient Rehabilitation	100%	70% after deductible
Substance Abuse Services - Outpatient	100% after $25 Copay	70% after deductible
Surgical Expenses Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures **Excludes Neonatal Circumcision**	100%	70% after deductible
Therapy and Rehabilitation Services (Cardiac Rehabilitation, Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy and Respiratory Therapy)	100%	70% after deductible
Transplant Services	100%	70% after deductible
Precertification Requirements	Yes[6]	
Condition Management	Case Management, Blues on Call, and Disease State Management	

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during a benefit period will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

[1] The maternity home health care visit for network care is not subject to the program Copay, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Covered Services section.

[2] For covered services rendered by a facility provider within the service area who has no contractual relationship with Highmark, the plan allowance will be 60% of the facility provider's billed charge for inpatient services and 40% of the facility provider's billed charge for outpatient services. For covered services rendered by an out-of-area provider, such services will be priced by the local Blue Cross Blue Shield plan and submitted to Highmark via BlueCard. The plan allowance would then be subject to the coinsurance percentage after your deductible, if any, has been satisfied.

[3] Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.

[4] If testing is required, cost sharing may apply as outlined under Diagnostic Services. Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

[5] Services are limited to those on a predefined schedule. Gender, age and frequency limits may apply.

[6] Highmark must be contacted prior to a planned inpatient admission or within 48 hours of an emergency inpatient admission. Some facility providers will contact Highmark and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark for precertification. If your provider does not, you are responsible for contacting Highmark. Also be sure to confirm Highmark's determination of medical necessity and appropriateness If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

Summary of PPO Blue *Benefits*

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Pennsylvania Turnpike Commission – Bronze Plan

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $6,600 $13,200	 $7,000 $14,000
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 $9,600 $19,200
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only)(2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $6,850 $13,700	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after deductible	70% after deductible
Primary Care Provider Office Visits	100% after deductible	70% after deductible
Specialist Office & Virtual Visits	100% after deductible	70% after deductible
Virtual Visit Originating Site Fee	100% after deductible	70% after deductible
Urgent Care Center Visits	100% after deductible	70% after deductible
Preventive Care(3)		
Routine Adult Physical exams	 100% (deductible does not apply)	 70% after deductible
Adult immunizations	100% (deductible does not apply)	70% after deductible
Colorectal cancer screening	100% (deductible does not apply)	70% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	70% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric Physical exams	 100% (deductible does not apply)	 70% after deductible
Pediatric immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	70% after deductible
Emergency Services		
Emergency Room Services	100% after deductible	
Ambulance	100% after deductible	
Ambulance – Non-Emergency	100% after deductible	70% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	70% after deductible Limit: 70 days/calendar year
Hospital Outpatient	100% after deductible	70% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	70% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	70% after deductible

Benefit	Network	Out-of-Network
Surgical Expenses (except office visits) Includes Assistant Surgery, Anesthesia, Sterilization, Reversal Procedures and Neonatal Circumcision	100% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after deductible	70% after deductible
	Unlimited visits/benefit period	
Respiratory Therapy	100% after deductible	70% after deductible
Speech & Occupational Therapy	100% after deductible	70% after deductible
	Unlimited visits per therapy/benefit period	
Spinal Manipulations	100% after deductible	70% after deductible
	Unlimited visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible
Mental Health/Substance Abuse		
Inpatient	100% after deductible	70% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	70% after deductible
Outpatient	100% after deductible	70% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	70% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Not Covered	Not Covered
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible
Home Health Care	100% after deductible	70% after deductible
	Limit: 90 visits/benefit period	
Hospice	100% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment(4)	100% after deductible	70% after deductible
Private Duty Nursing	100% after deductible	70% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	70% after deductible
	Limit: 100 days/benefit period	
Transplant Services	100% after deductible	70% after deductible
Precertification Requirements(5)	YES	

(1) Your group's benefit period is based on a Calendar Year.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government, TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. Effective with plan years beginning on or after January 1, 2016, TMOOP cannot be more than $6,850 for individual and $13,700 for two or more persons.

(3) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.

(4) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

(5) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	None Individual None Family	$400 Individual $800 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	70%
Payment Limit (per calendar year)	None Individual None Family	$1,500 Individual $3,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.		
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required		
Lifetime Maximum	Unlimited except where otherwise indicated.	
Primary Care Physician Selection	Not Applicable	Not Applicable
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100% after $15 copay	70%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100% after $15 copay	70%; after deductible
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22.		
Routine Gynecological Care Exams Includes routine tests and related lab fees.	Covered 100% after $25 copay	70%; after deductible
Routine Mammograms	Covered 100%	70%; after deductible
Starting at age 40, as recommended by your Doctor. High Risk: Earlier or more frequent testing if recommended by your doctor		
Colorectal Cancer Screening	Covered 100%	70%; after deductible
Recommended: For all members age 50 and over. High Risk: Earlier or more frequent testing if recommended by your doctor.		
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$15 office visit copay	70%; after deductible
Specialist Office Visits	$25 office visit copay	70%; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	Covered 100%	70%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Laboratory	Covered 100%	70%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		

Diagnostic Outpatient Complex Imaging	Covered 100%	70%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$25 copay	70%; after deductible
Emergency Room	$50 copay; deductible waived if admitted	
Ambulance	Covered 100%	Covered 70%; after deductible
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100%	70%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage (includes dependent daughters)	Covered 100%	70%; after deductible
Outpatient Hospital Expenses	Covered 100%	70%; after deductible
Outpatient Surgery	Covered 100%	70%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%	70%; after deductible
Outpatient	$25 copay	70%; after deductible
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100%	70%; after deductible
Outpatient	$25 copay	70%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Convalescent Facility	Covered 100% Combined limit of 100 days per calendar year.	70%; after deductible
Home Health Care	Covered 100% Combined limit of 90 visits per calendar year.	70%
Hospice Care	Covered 100%	70%; after deductible
Private Duty Nursing	Covered 100% Combined limit of 240 hours maximum per calendar year.	70%; after deductible
Outpatient Short-Term Rehabilitation	$25 copay	70%; after deductible
Includes Speech, Physical, and Occupational Therapy, Combined limit of 20 visits per calendar year for Physical Therapy. Combined Limit of 12 visits per calendar year for Speech and Occupational Therapy.		
Spinal Manipulation Therapy	$25 copay Combined limit of 20 visits per calendar year.	70%; after deductible
Durable Medical Equipment	Covered 100%	70%; after deductible
Diabetic Supplies	Covered 100%	70%; after deductible
Transplants	Covered 100%	70%; after deductible
Routine Hearing Care Services	Covered 100% Combined Limit: $350 allowance per 36 month period (hearing aid must be purchased within 6 months of evaluations)	

Prescription Drug Plan for Active Employees

Your Aetna Prescription Drug program is a three-tiered open formulary plan with a mandatory generic provision.

Copays	Retail network pharmacy	Retail network pharmacy	CVS retail pharmacy	Aetna mail-order pharmacy	Aetna Specialty mail-order pharmacy
	Up to 31-day supply	31-day supply (on or after 3rd fill of maintenance medications)	90-day supply	31 – 90-day supply	30-day supply
Generic	$10	$25	$20	$20	$15
Preferred brand	$23	$41	$32	$32	$23
Nonpreferred brand	$41	$77	$59	$59	$41

Copayments

Retail	This copay applies up to the 31-day maximum supply of prescription medicine dispensed at retail pharmacies.
Mail order	This copay applies up to a 90-day supply of medication for all prescriptions for maintenance medicines that are taken regularly for chronic conditions such as: arthritis, asthma, diabetes and high cholesterol.
CVS	This copay applies to 90-day supply for all prescriptions for maintenance medicines that are taken regularly.
Retail maintenance	This copay applies starting with the third retail fill of up to a 31-day supply of a prescription and all refills thereafter.
Mandatory generics	This provision applies if you select a brand-name medicine for a retail mail-order prescription when a generic brand medicine is available. In this case, you will pay the applicable preferred or nonpreferred copay plus the difference in the cost between the generic and brand-name medicines. If the doctor indicates there is no substitution allowed for a brand-name medicine, the employee will pay only the applicable brand copay.

With your prescription drug benefits, there are two ways to keep prescription medication costs low.

1. Choose generic medicine instead of brand-name, if it's right for you.
2. If a generic is not available, choose a preferred brand-name drug. Refer to our Preferred Drug List to see what drugs are considered preferred.

Generic medicine

Your plan covers all generic medicine at the lowest retail, mail order and retail maintenance copays. Generic medicines are:

- The same as brand-name medicine in dose, strength, quality, the way they are administered and the way they are meant to be used
- Less costly than the brand-name medicine although they contain the same active ingredients
- Included in the plan at the generic copay as they become available
- All approved by the U.S. Food and Drug Administration (FDA)

Preferred brand-name medicine

Your plan uses Aetna's Preferred Drug List. We work with a team of health care provider to decide what medications to put on the list.

The list shows you medicines that are:

- Brand-name and covered on a preferred basis
- Chosen on the basis of sound medical data, safety and cost
- Reviewed by our Pharmacy and Therapeutic (P&T) Committee for inclusion on the Preferred Drug List. The committee is comprised of Aetna staff, practicing doctors and pharmacists who are chosen to represent various clinical specialties.
- Updated on a regular basis and subject to change
- All approved by the U.S. Food and Drug Administration (FDA)

To view a complete list of preferred medicine, visit www.aetna.com/formulary. Or, call toll-free 1-888-792-3862.

Nonpreferred brand-name medicine

This type of medicine is not found on the Preferred Drug List because Aetna does not consider such medicine to be as safe or cost-effective. The P&T's clinical decisions are based on the strength of scientific evidence including relevant findings of federal government agencies, pharmaceutical manufacturers and medical professionals.

Rx Member Services
1-888-792-3862

Mon. – Fri. 7 a.m. to 11 p.m. (ET)
Sat. 7 a.m. to 9:30 p.m. (ET)
Sun. 8 a.m. to 5:30 p.m. (ET)

You can have medications delivered to your door

Do you take medications every day to control a health condition? Use our Aetna Rx Home Delivery® mail-order pharmacy. You can get up to a 90-day supply, or the maximum supply allowed by your plan, delivered right to your mailbox.

You also get:

- Quick, confidential service
- Free standard shipping
- Pharmacists who check all prescriptions for accuracy and can answer questions anytime

It's easy and fast to order — choose one of these ways:

1. Mail – Get a new prescription from your doctor. Mail your new prescription to Aetna Rx Home Delivery with a completed order form. You can access the form online. Visit www.aetnanavigator.com and log in to your secure Aetna Navigator member website. Once logged in, click the link to "Aetna Pharmacy."

2. Fax – Give your doctor the Aetna Rx Home Delivery fax number: 1-877-270-3317. Your doctor can fax in the prescription. Make sure your doctor includes your member ID number, your date of birth and your mailing address on the fax cover sheet. Only a doctor may fax a prescription.

3. Phone – Call Rx Member Services toll-free at 1-888-RX AETNA (1-888-792-3862). With our Aetna Rx Courtesy Start℠ program, we will contact your doctor to attempt to get a new prescription. Your doctor may require you to schedule a visit before he or she will write you a new prescription. After we reach out to your doctor, please allow adequate time (up to 7 days) for us to receive a reply. To help this process move quickly, we highly recommend you alert your doctor to expect our outreach.

Ordering refills is easy. You can order refills:

1. Online – Visit www.aetnanavigator.com and log in to Aetna Navigator to order refills, track your order and more.

2. By phone – Call Rx Member Services toll-free at 1-888-RX AETNA (1-888-792-3862). Have your Aetna member ID number, your prescription number and your credit card number ready.

3. By mail – Send in the reorder form that you received with your last order. Mail it back with your payment. The reorder form will also tell you when you can place your next refill order.

Get delivery and support services for specialty medications

Use our Aetna Specialty Pharmacy® services for specialty drugs that may be injected, infused or taken by mouth. Specialty medicine often needs special storage and handling. It must be delivered quickly. And a nurse or pharmacist should monitor you during your treatment. Aetna Specialty Pharmacy delivers these medicines right to your mailbox.You also get:

- Free delivery that is reliable, secure and sent anywhere you choose.
- Extra help when you need it — like injection training and side effect monitoring.
- Proactive outreach to confirm your refills.
- Free standard supplies.
- Nurses and pharmacists who can help you 24 hours a day, every day.

It's easy and fast to order — choose one of these ways:

1. Fax – Your doctor may fax your prescription to 1-866-FAX-ASRX (1-866-329-2779).

2. Mail – You or your doctor may mail your prescription order to: Aetna Specialty Pharmacy, 503 Sunport Lane, Orlando, FL 32809. If you mail in your own prescription, please send it along with a completed Patient Profile Form. To access this form, visit www.aetnaspecialtyrx.com and click "Enroll."

3. Phone – Your doctor may also call and speak to one of our registered pharmacists at 1-866-782-ASRX (1-866-782 2779) during normal business hours of 8 a.m. until 7 p.m. ET. To transfer an existing prescription order to be filled by Aetna Specialty Pharmacy, call toll-free at 1-866-353-1892.

Reliable information about your medicine

To learn about your prescriptions and your health, visit www.aetnanavigator.com and log in to Aetna Navigator.

- Possible medicine side-effects
- Generic substitutes
- Medicine safety
- Tips for saving money and answers to benefits questions
- Specialty injectable medicine
- Preferred brand-name medicines

Delivery or pick-up?

Get up to a 90-day supply of your maintenance medicine, by mail or in person

Do you take maintenance medicines regularly? These are drugs that treat conditions like arthritis, asthma, diabetes or high cholesterol. If you need this type of drug, you can get a 90-day supply. The Maintenance Choice® program gives you a choice of two ways to save and pay the same amount either way. You can choose to use either Aetna Rx Home Delivery mail-order pharmacy or a CVS pharmacy* near you.

Plan exclusions

This plan does not cover every medicine your doctor might prescribe. For example, medications prescribed for cosmetic purposes or for enhancing physical performance are typically not covered. The plan also does not cover replacement of lost or stolen prescriptions.

Participating pharmacies

To view a complete list of in-network pharmacies, visit www.aetnanavigator.com and log in to Aetna Navigator. Then click "Find a Doctor, Pharmacy or Facility." If you visit a pharmacy outside of the Aetna network, you will pay full price for your prescription medications and must submit a claim for reimbursement. You may be reimbursed at a lower amount than the amount charged by the out-of-network pharmacy.

Health benefits and health insurance plans are offered, administered and/or underwritten by Aetna Health Inc., Aetna Health Insurance Company of New York, Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna). In Florida, by Aetna Health Inc. and/or Aetna Life Insurance Company. In Maryland, by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products.

Aetna Pharmacy Management refers to an internal business unit of Aetna Health Management, LLC.

*Customers in Hawaii only may use a Longs Drugs location.

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

Prescription Drug Plan for Retirees

Your Aetna Prescription Drug program is a three-tiered open formulary plan with a mandatory generic provision.

Copays for Under Age 65 Retirees, Spouses and Dependents

	Retail network pharmacy Up to 31-day supply	Retail network pharmacy 31-day supply (on or after 3rd fill of maintenance medications)	CVS retail pharmacy 90-day supply	Aetna mail-order pharmacy 31 – 90-day supply	Aetna Specialty mail-order pharmacy 30-day supply
Generic	$10	$25	$20	$20	$15
Preferred Brand	$23	$41	$32	$32	$23
Nonpreferred Brand	$41	$77	$59	$59	$41

Copays for Age 65 and Older Retirees, Spouses and Dependents

	Retail pharmacy Up to 31-day supply	Mail order/CVS retail pharmacy Up to 90-day supply	Retail maintenance Up to 31-day supply
Generic	$10 or 20% whichever is greater	$20 or 20% whichever is greater	$25 or 20% whichever is greater
Preferred brand	$23 or 20% whichever is greater	$32 or 20% whichever is greater	$41 or 20% whichever is greater
Nonpreferred brand	$41 or 20% whichever is greater	$59 or 20% whichever is greater	$77 or 20% whichever is greater

Copayments

The level of coverage varies based on age for you, your spouse and dependents.

Retail	This copay applies up to the 31-day maximum supply of prescription medicine dispensed at retail pharmacies.
Mail order	This copay applies up to a 90-day supply of medication for all prescriptions for maintenance medicines that are taken regularly for chronic conditions such as: arthritis, asthma, diabetes and high cholesterol.
CVS	This copay applies to 90-day supply for all prescriptions for maintenance medicines that are taken regularly.
Retail maintenance	This copay applies starting with the third retail fill of up to a 31-day supply of a maintenance prescription and all refills thereafter.
Mandatory generics	This provision applies if you select a brand-name medicine for a retail mail-order prescription when a generic brand medicine is available. In this case, the employee will pay the applicable preferred or nonpreferred copay plus the difference in the cost between the generic and brand-name medicines. If the doctor indicates there is no substitution allowed for a brand-name medicine, the employee will pay only the applicable brand copay.

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Mon. – Fri. 7 a.m. to 11 p.m. (ET)
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PENNA TURN PIKE

You can have medications delivered to your door

Do you take medications every day to control a health condition? Use our Aetna Rx Home Delivery® mail-order pharmacy. You can get up to a 90-day supply, or the maximum supply allowed by your plan, delivered right to your mailbox.

You also get:

- Quick, confidential service
- Free standard shipping
- Pharmacists who check all prescriptions for accuracy and can answer questions anytime

It's easy and fast to order — choose one of these ways:

1. Mail – Get a new prescription from your doctor. Mail your new prescription to Aetna Rx Home Delivery with a completed order form. You can access the form online. Visit www.aetnanavigator.com and log in to your secure Aetna Navigator member website. Once logged in, click the link to "Aetna Pharmacy."

2. Fax – Give your doctor the Aetna Rx Home Delivery fax number: 1-877-270-3317. Your doctor can fax in the prescription. Make sure your doctor includes your member ID number, your date of birth and your mailing address on the fax cover sheet. Only a doctor may fax a prescription.

3. Phone – Call Rx Member Services toll-free at 1-888-RX AETNA (1-888-792-3862). With our Aetna Rx Courtesy Start℠ program, we will contact your doctor to attempt to get a new prescription. Your doctor may require you to schedule a visit before he or she will write you a new prescription. After we reach out to your doctor, please allow adequate time (up to 7 days) for us to receive a reply. To help this process move quickly, we highly recommend you alert your doctor to expect our outreach.

Ordering refills is easy. You can order refills:

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2. By phone – Call Rx Member Services toll-free at 1-888-RX AETNA (1-888-792-3862). Have your Aetna member ID number, your prescription number and your credit card number ready.

3. By mail – Send in the reorder form that you received with your last order. Mail it back with your payment. The reorder form will also tell you when you can place your next refill order.

Get delivery and support services for specialty medications

Use our Aetna Specialty Pharmacy® services for specialty drugs that may be injected, infused or taken by mouth. Specialty medicine often needs special storage and handling. It must be delivered quickly. And a nurse or pharmacist should monitor you during your treatment. Aetna Specialty Pharmacy delivers these medicines right to your mailbox.

You also get:

- Free delivery that is reliable, secure and sent anywhere you choose
- Extra help when you need it — like injection training and side effect monitoring
- Proactive outreach to confirm your refills
- Free standard supplies
- Nurses and pharmacists who can help you 24 hours a day, every day

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1. Fax – Your doctor may fax your prescription to 1-866-FAX-ASRX (1-866-329-2779).

2. Mail – You or your doctor may mail your prescription order to: Aetna Specialty Pharmacy, 503 Sunport Lane, Orlando, FL 32809. If you mail in your own prescription, please send it along with a completed Patient Profile Form. To access this form, visit www.aetnaspecialtyrx.com and click "Enroll."

3. Phone – Your doctor may also call and speak to one of our registered pharmacists at 1-866-782-ASRX (1-866-782 2779) during normal business hours of 8 a.m. until 7 p.m. ET. To transfer an existing prescription order to be filled by Aetna Specialty Pharmacy, call toll-free at 1-866-353-1892.

Reliable information about your medicine

To learn about your prescriptions and your health, visit www.aetnanavigator.com and log in to Aetna Navigator. Learn about:

- Possible medicine side-effects
- Generic substitutes
- Medicine safety
- Tips for saving money and answers to benefits questions
- Specialty injectable medicine
- Preferred brand-name medicines

Delivery or pick-up?

Get up to a 90-day supply of your maintenance medicine, by mail or in person

Do you take maintenance medicines regularly? These are drugs that treat conditions like arthritis, asthma, diabetes or high cholesterol. If you need this type of drug, you can get a 90-day supply. The Maintenance Choice® program gives you a choice of two ways to save and pay the same amount either way. You can choose to use either Aetna Rx Home Delivery mail-order pharmacy or a CVS pharmacy* near you.

Plan exclusions

This plan does not cover every medicine your doctor might prescribe. For example, medications prescribed for cosmetic purposes or for enhancing physical performance are typically not covered. The plan does not cover replacement of lost or stolen prescriptions.

Participating pharmacies

To view a complete list of in-network pharmacies, visit www.aetnanavigator.com and log in to Aetna Navigator. Then click "Find a Doctor, Pharmacy or Facility." If you visit a pharmacy outside of the Aetna network, you will pay full price for your prescription medications and must submit a claim for reimbursement. You may be reimbursed at a lower amount than the amount charged by the out-of-network pharmacy.

Health benefits and health insurance plans are offered, administered and/or underwritten by Aetna Health Inc., Aetna Health Insurance Company of New York, Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna). In Florida, by Aetna Health Inc. and/or Aetna Life Insurance Company. In Maryland, by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products.

Aetna Pharmacy Management refers to an internal business unit of Aetna Health Management, LLC.

*Customers in Hawaii only may use a Longs Drugs location.

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UNITED CONCORDIA® DENTAL

Dental Benefits Summary for PA Turnpike Commission

Network: Concordia Advantage Plus

Benefit Category	Concordia Flex Plan	Payment
Class I - Diagnostic/Preventative Services		
Routine Exams	Limited to once during a 6 consecutive month period	Plan pays 100% Member Pays 0%
X-Rays	• Periapical x-rays – as required • Bitewing x-rays – once during a 6 consecutive month period • Full mouth x-rays once in any 36 months	
Fluoride Treatments	Once during any period of 6 consecutive months for dependent children under age 19	
Cleanings	Once during a 6 consecutive month period (includes an additional cleaning for women during pregnancy)	
Sealants	• For dependent children through age 10 on permanent first molars and through age 15 on permanent second molars • One sealant per tooth per 3 years	
Palliative Treatment	Emergency treatment of an acute condition requiring immediate care	
Class II – Basic Services		
Basic Restorative	Fillings consisting of silver amalgam and synthetic tooth colored restorations	Plan pays 100% Member Pays 0%
Simple Extractions	Nonsurgical extractions	
Repairs	Minor repairs on broken dentures	
Endodontics	Endodontic procedures covered	
General Anesthesia	Covered for certain services when general anesthesia is medically necessary and when performed by or under the supervision of a dentist	
Class III – Major Services		
Inlays, Onlays and Crowns Prosthetics Replacement	Prefabricated stainless steel crowns are limited to one per tooth per lifetime Eligible Of existing crowns, inlays, onlays or prosthetic appliances limited to once in 5 years	Plan pays 100% Member pays 0%
Denture reline and rebase	• Integral if provided within 6 months of insertion by the same dentist • Subsequent services limited to once every 36 months	
Periodontal Treatment	• Crown lengthening limited to one per tooth per lifetime • Periodontal scaling and root planning limited to once per 24 months per area of mouth • Two per calendar year per member (in addition to routine cleanings) following active periodontal therapy	
Oral Surgery	• Surgical removal of teeth • Surgical removal of intra-boney cysts of the upper and lower jaws • Procedures performed for preparation of the mouth for dentures • Apicoectomy (dental root removal)	
Implant Services		
	• Limited to one per tooth per lifetime • Limited to members age 18 and older • Inclusive of $2,500 annual program maximums	Plan pays 100% Member pays 0%
Orthodontics		
Diagnostic, Active, Retention Treatment	• Diagnosis is covered, including x-rays • Active treatment including necessary appliances and retention treatment • Subscribers to any age are eligible	Plan pays 75% Member pays 25%
Maximums & Deductibles		
Calendar Year Deductible Calendar Year Maximum Lifetime Ortho Maximum	Per person/per family Per Person Per Person	$0 $2,500 $3,500

Representative listing of covered services – certificate of coverage provides a detail description of benefits.

WWW.UnitedConcordia.com **1-800-332-0366**

Note: Payment levels are based on the UCCI Advantage Schedule of Maximum Allowances or the provider charge whichever is lower. Covered services eligible only when performed by or under the direct supervision of a dentist. Predetermination review may be required to determine extent of proposed services, necessity of proposed services and the amount of liability. Impactions (except soft tissue), surgical excisions (except opereulectomies), and general anesthesia for the surgical services listed herein are excluded from the annual program.

Dental Benefits Summary for PA Turnpike Commission

Advantages of Visiting a Participating Provider

Participating dentists will:

- Accept United Concordia's maximum allowable charge (MAC) as payment in full
- Not balance-bill for charges over the MAC
- Submit claims on your behalf

Example:
Participating dentist charges $50* for an adult cleaning. United Concordia's maximum allowable charge for this service is $40. The plan pays 100% of the allowance or $40. You are responsible for $0.

Nonparticipating dentists will:

- *Not* accept United Concordia's MAC as payment in full
- Balance-bill for amounts that that exceed the MAC, up to the provider's charge
- *Not* submit claims on your behalf

Example:
Nonparticipating dentist charges $50 for an adult cleaning. United Concordia's maximum allowable charge for this service is $40. The plan pays 100% of the allowance or $40. You will be responsible for the difference between United Concordia's MAC and the nonparticipating dentist's charge ($10). So, you will be responsible for $10.

*Allowances used are for illustrative purposes only.

My Dental Benefits

Visit My Dental Benefits at **www.unitedconcordia.com** to access:

- **Eligibility-** Summary showing your group name, plan type, etc.
- **Member listing-** Listing of all persons covered under your contract
- **Benefit information-** Benefit details sorted into easy-to-search categories
- **Claim information-** Claim status updates with payment details
- **Maximum/deductible-** Details on maximums and deductibles paid
- **Procedure history-** Snapshot of dental care provided to a member over the past 2 to 5 years, while a member of United Concordia
- **ID card reissue-** Easy-to-use way to order additional ID cards or print one online
- **Find a dentist-** Quick link to search for a participating dentist
- **Contact us-** Email questions to Customer Service

www.UnitedConcordia.com • 1-800-332-0366

Note: Payment levels are based on the UCCI Advantage Schedule of Maximum Allowances or the provider charge whichever is lower. Covered services eligible only when performed by or under the direct supervision of a dentist. Predetermination review may be required to determine extent of proposed services, necessity of proposed services and the amount of liability. Impactions (except soft tissue), surgical excisions (except opereulectomies), and general anesthesia for the surgical services listed herein are excluded from the annual program maximum.

Premier Advantage Vision Program

BENEFIT	NETWORK	OUT-OF-NETWORK REIMBURSEMENT[1]
FREQUENCY[2]		
Eye examination (including dilation, as professionally indicated)	Once every 12 months	
Evaluation and Fitting of Contact Lenses	Once every 12 months	
Eyeglass lenses (frames and eyeglass lenses)	Once every 12 months under age 19/24 months of age 19 or older	
Contact lenses (in lieu of frames and eyeglass lenses)	Once every 12 months under age 19/24 months of age 19 or older	
EYE EXAMINATION		
Including dilation as professionally indicated	Covered In Full	Up to $40 allowance
FRAMES		
Premier, Designer, & Fashion level frames from "The Collection"	Covered In Full	
Retail allowance towards a provider's frame	Up to $100 wholesale allowance at independent provider locations and up to $100 retail allowance at retail locations	Up to $100 allowance
STANDARD EYEGLASS LENSES[3] (per pair)		
Single vision	Covered In Full	Up to $36 allowance
Bifocal	Covered In Full	Up to $48 allowance
Trifocal	Covered In Full	Up to $58 allowance
Lenticular	Covered In Full	Up to $95 allowance
OPTIONAL EYEGLASS LENSES (per pair)		
Standard progressive lenses[4]	Covered In Full	Up to $108 allowance
Premium progressive lenses[4]	Covered In Full	Up to $108 allowance
Glass Grey #3 prescription sunglasses	Covered In Full	Not Covered
Polycarbonate lenses		
Adult[5]	$30 discounted price	Not Covered
Dependent children		
Single vision Polycarbonate lenses (in lieu of single vision eyeglass lenses)	Covered In Full	Up to $70 allowance
Bifocal Polycarbonate lenses (in lieu of bifocal eyeglass lenses)	Covered In Full	Up to $80 allowance
Trifocal Polycarbonate lenses (in lieu of trifocal eyeglass lenses)	Covered In Full	Up to $95 allowance
Blended segment lenses	$20 discounted price	Not Covered
Intermediate vision lenses	$30 discounted price	Not Covered
Glass photochromic lenses	$20 discounted price	Not Covered
Plastic photosensitive lenses	Covered In Full	Not covered
High-index (thinner and lighter) lenses	Covered In Full	Not Covered
Polarized lenses[6]	$75 discounted price	Not Covered
OPTIONAL EYEGLASS LENS COATINGS/TREATMENTS		
Fashion, sun or gradient tinted plastic lenses	Covered In Full	Not Covered
Ultraviolet coating[6]	$12 discounted price	Not Covered
Scratch-resistant coating	$20 discounted price	Not Covered
Standard ARC (anti-reflective coating)	$35 discounted price	Not Covered
Premium ARC (anti-reflective coating)	$48 discounted price	Not Covered
Ultra ARC (anti-reflective coating)	$60 discounted price	Not Covered
CONTACT LENSES[7] (in lieu of eyeglass lenses – per pair or initial supply of disposable contact lenses)		
Contact lens evaluation and fitting		
Daily wear	Covered in full	Up to $20 allowance
Extended wear	Covered in full	Up to $30 allowance
Standard daily wear contact lenses	Covered in full	Up to $300 allowance
Specialty contact lenses	Up to $300 allowance	Up to $300 allowance
Disposable contact lenses	Up to $300 allowance	Up to $300 allowance
Medically necessary contact lenses (prior approval required)	Covered In Full	Up to $225 allowance
LOW VISION SERVICES		
Evaluation – one visit every 5 years (prior approval required)	Up to $300 allowance per visit	
Follow-up visits – up to four follow-up visits every 5 years	Up to $100 allowance per visit	
Low vision aids	Up to $600 allowance per aid/$1,200 allowance lifetime maximum	

(1) If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement.
(2) Eligibility will be determined from the date of the last similar service paid under this program, or any other Highmark Blue Shield vision program for this group.
(3) Includes glass, plastic or oversized lenses.
(4) Progressive multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive lenses, however the discounted price will not be refunded.
(5) Discounted member price waived for monocular patients and patients with prescriptions +/- 6.00 diopters or greater.
(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.
(7) Contact lenses can be worn by most people. Once the contact lens option is selected and the lenses fitted, they may not be exchanged for eyeglasses.

Employees/Retirees only are eligible for 1 of theses 3 items every 12 months: prescription eyeglasses, prescription contact lenses or prescription sunglasses.

This is a summary of the vision benefits. Please refer to the group contract for complete benefit information. Should the information in this summary differ from the information contained in the group contract, the terms of the group contract shall govern.

Network providers—The Davis Vision provider network is being used through a contractual arrangement between Davis Vision and Highmark. Davis Vision is an independent company that manages a network of licensed vision providers in both private practice and retail locations. Network providers are reviewed and credentialed to ensure that standards for quality and service are maintained.

Network retail locations—In order to provide you with the greatest amount of flexibility and convenience, the network includes a number of retail establishments. Benefits at the retail locations may vary slightly from other locations, as noted in this benefit description. However, your value is comparable.

Locating a network provider—To find a network provider, go to www.highmarkblueshield.com and click on "find a vision network provider." Click "OK" to be redirected to the Davis Vision, Inc. Web site. Enter your zip code and mile radius then click on "Search" to see the most current listing of providers that will accept your vision plan.

Receiving services from a network provider:

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a Highmark member, or eligible dependent, in a vision plan administered by Davis Vision.
- Provide the office with your identification (ID) number (located on your Highmark ID card), and the name and birth date of the covered dependent receiving services.

It's that easy! The provider's office will verify your eligibility for services. No claim forms are required!

Frame benefit—You may choose from 'The Collection' in most independent network provider offices or a program allowance will be applied toward a network provider's own frames. Many Collection frames are covered in full or have a nominal copayment which helps you select high-quality frames, while minimizing out-of-pocket expenses. Network retail providers typically do not display the Collection. You will instead be given a program allowance toward your frame purchase. If the chosen frame exceeds the allowance, you will be responsible for any remaining balance.

Contact lenses benefit—If you select contact lenses in lieu of eyeglass lenses you will receive a contact lens evaluation and fitting covered in full. In addition, you will receive a program allowance toward the cost of elective contact lenses at network provider locations. With prior approval, medically necessary contact lenses will be covered in full at all network provider locations.

Low vision services—You and your covered dependents are entitled to a comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Up to four follow-up visits will be covered during the five-year period.

Exclusions—This vision program excludes coverage for certain items and services, including: medical treatment of eye disease or injury; vision therapy; special lens designs or coatings other than those previously described; replacement of lost or stolen eyewear; non-prescription (plano) lenses; and services not performed by licensed personnel.

VALUE-ADDED FEATURES

Replacement contact lens program—Highmark offers a contact lens replacement program to members. This mail order program, Lens 1-2-3®, exclusively allows you to enjoy the guaranteed lowest prices on contact lens replacement materials. Call 1-800-LENS-123 or visit www.LENS123.com with a current prescription. Every order comes with a complimentary starter kit.

Information about laser vision correction services—You and your covered dependents can receive substantial discounts on laser correction procedures. You are entitled to savings of up to 25% off the provider's usual and customary fees, or a 5% discount on any advertised special through a network of credentialed physicians affiliated with Eye Centers of Excellence. (Some centers provide a flat fee equating to these discount levels.)

Call Member Service Monday through Friday, 8:00 am to 5:00 pm, Eastern Standard Time (EST) at 1-800-223-4795 (TTY users call 1-800-523-2847) to find a network provider, ask benefit questions, verify eligibility or request an out-of-network provider reimbursement form.

For information prior to enrolling, call 1-800-223-4795.

HIGHMARK. | Signature 65

2016 Summary of Benefits

Signature 65 is a Medicare-complementary benefit program that supplements coverage gaps and member costs of the traditional Medicare program (Medicare Part A and Medicare Part B). Traditional Medicare benefits are sometimes called **"Original Medicare."** In order to be enrolled in Signature 65 and receive supplemental benefits, **you must be enrolled in Medicare Part A and Medicare Part B**.

Benefits are based on where the services are provided and who provides them. Signature 65 complements your Medicare benefits by paying for some or all of the deductibles or coinsurance that are not covered by Medicare alone. Signature 65 also provides additional benefits, which are not covered by Medicare. Following is an outline of how your benefits will pay with Medicare and Signature 65.

Medicare Part A Covered Hospital Services			
Covered Services	**Medicare Pays**	**Signature 65 Pays**	**Member Pays①**
Inpatient Hospital Days 1-60	All but Part A Deductible	Medicare Part A Deductible ③	$0
Inpatient Hospital Days 61-90	80%	20% Coinsurance	$0
Inpatient Hospital Days 91-150 (may be used once per lifetime)	80%	20% Coinsurance	$0
Additional Inpatient Hospital Days	$0	100% of Medicare-eligible expenses for 365 additional days after the 60 Medicare inpatient hospital lifetime reserve days are exhausted.	$0 for the first 365 additional inpatient hospital days per benefit period.
Skilled Nursing Facility Days 1-20	100%	$0	$0
Skilled Nursing Facility Days 21-100	80%	20% Coinsurance	$0
Skilled Nursing Facility Days 101 and beyond	$0	$0	100%
Anesthesia	80%	20% Coinsurance	$0
Blood (Inpatient)	$0 for the first 3 pints per calendar year, 100% thereafter.	100% for the first 3 pints per calendar year, $0 thereafter.	$0
Home Health Care Visits	100%	$0	$0
Hospice Care	100% (except as noted)	$0	Copayment of up to $5 per prescription for drugs used for symptom control or pain relief. 5% of Medicare-approved amount for inpatient respite care.

Medicare Part B Medically Necessary Covered Doctor and other Medical Services			
Covered Services ②	**Medicare Pays**	**Signature 65 Pays**	**Member Pays ①**
Most Medicare Part B Covered Services, including, but not limited to: ▪ Anesthesia ▪ Ambulance ▪ Ambulatory Surgical Center ▪ Cardiac Rehabilitation ▪ Chemotherapy ▪ Chiropractic Services ▪ Clinical Lab Services ▪ Diabetes Supplies and Services ▪ Diagnostic Tests ▪ Doctor Services ▪ Durable Medical Equipment ▪ Emergency Room Services ▪ Home Health Services ▪ Kidney Dialysis ▪ Occupational Therapy ▪ Outpatient Hospital Services ▪ Physical Therapy ▪ (Part B) Prescription Drugs ▪ Prosthetics and Orthotics ▪ Pulmonary Rehabilitation ▪ Radiation Therapy ▪ Speech-Language Pathology ▪ Surgical Services	80% of Medicare-approved amount	20% of Medicare-approved amount	Medicare Part B Deductible③
Outpatient Mental Health and Substance Abuse	80% of Medicare-approved amount	20% of Medicare-approved amount	Medicare Part B Deductible③
Blood (Outpatient)	$0 for the first 3 pints per calendar year; 80% after the Part B Deductible.	100% for the first 3 pints per calendar year; 20% thereafter.	$0 for the first 3 pints per calendar year; then the member must meet the Medicare Part B Deductible③. $0 cost to the member after the deductible has been met for the year.

Medicare Part B Preventive Services	
Covered Screening/Procedures	**Description/Coverage Level** **<u>Medicare Pays</u>** **All but the Part B Deductible and Part B Coinsurance** **<u>Signature 65 Pays</u>** **Medicare Part B - 20% Coinsurance** **(Coinsurance is based on Medicare-approved amount)** **<u>Member Pays</u>** **Medicare Part B - Deductible③**
Abdominal Aortic Aneurysm Screening	One time screening ultrasound for people at risk.
Alcohol Misuse Counseling	One alcohol misuse screening per year.
Bone Mass Measurements	Once every 24 months for those that meet the criteria.
Cardiovascular Screenings	Covered once every 5 years to test your cholesterol, lipid, and triglyceride levels.
Cardiovascular Behavioral Therapy	One visit per year with primary care doctor to help lower cardiovascular risks.
Cervical and Vaginal Cancer Screenings	Pap tests and pelvic exams.
Colorectal Cancer Screening	Fecal Occult Blood Test - once every 12 months age 50 or older Flexible Sigmoidoscopy - once every 48 months age 50 or older, 120 months after previous Colonoscopy Colonoscopy - once every 120 months, 48 months after a previous flexible sigmoidoscopy, no minimum age Barium Enema - once every 48 months if age 50 or older, 24 months for high risk
Depression Screening	Once depression screening per year.
Diabetes Monitoring	Diabetes Screenings – covered if you have high risk factors. May be eligible for up to 2 diabetes screenings every year. Diabetes Self-Management Training Program
Glaucoma Testing	Covered once every 12 months for people at high risk
Gynecological Services	Pap Tests, Pelvic Exams, and Clinical Breast Exams – checks for cervical, vaginal and breast cancers are covered once every 24 months, or once every 12 months for women at high risk, or women of child bearing age that have shown cancer or another abnormality in the last 3 years.
HIV Screening	HIV screening for certain at-risk individuals
Mammogram Screening	Covered once every 12 months for all women with Medicare age 40 or older; and one mammogram for women 35-39 years old.
Medical Nutrition Therapy Services	Covered if you have diabetes or kidney disease or if you had a kidney transplant in the last 36 months and your provider refers you.
Obesity Screening and Counseling	Intensive weight loss counseling if you have a body mass index of 30 or more.
Physical Examinations	One-time “Welcome to Medicare” physical exam, includes screening, shots and referrals; must get the exam within the first 12 months of receiving Part B.

	Yearly "Wellness Exam" – after being enrolled in Part B for longer than 12 months, the yearly wellness visit allows you to develop or update a personalized prevention plan.
Prostate Cancer Screening	Covered once every 12 months for men over 50 years old
Sexually Transmitted Infections – Screening and Counseling	Covered for STI infections and up to two individual behavioral counseling sessions each year.
Some Vaccinations	Flu Shot - covered once a season in fall or winter Hepatitis B Shot - covered for people at high or medium risk Pneumococcal Shot - once in a lifetime
Smoking Cessation	Covered for up to 8 face-to-face visits in a 12 month period.

Prevention is the first step in staying healthy, so your Medicare and Signature 65 benefits pay for many preventive services. Check www.medicare.gov for more information about these preventive services.

Additional Benefits covered by Highmark Signature 65 - NOT covered by Medicare			
Covered Services	**Medicare Pays**	**Plan Pays**	**Member Pays** ①
Chemotherapy	$0	100% of the provider's reasonable charge	$0
Colorectal Cancer Screenings	$0	100% of the provider's reasonable charge	$0
Emergency Care in a Foreign Country (for services equivalent to those that would have been covered by Medicare if they had been provided in the United States)	$0	100% of the provider's reasonable charge	$0
Enteral Formulae	$0	100% of the provider's reasonable charge	$0
Routine Gynecological Exams	$0	100% of the provider's reasonable charge	$0

① If the provider does not accept assignment from Medicare, any difference between the provider's charge and the combined Medicare/Highmark payment shall be the personal responsibility of the member.

② For more information on services covered by Medicare, see the **'Medicare and You 2016'** publication available from CMS at www.medicare.gov. Signature 65 is a supplement to the services that are covered by Medicare. All Medicare enrollees are entitled to this publication.

③ 2016 Deductibles: Medicare Part A Deductible is $1,288 and Medicare Part B Deductible is $166.

		PA Turnpike	Freedom Blue PPO w/Rx 178349, 178351, 178356 & 178357
			In Network	Out Of Network
BASIC PLAN COSTS		Deductible	$0	$0
		Coinsurance	$0	20%
		Out-of-Pocket Maximum	$3400	
PREVENTIVE CARE (OFFICE VISIT COST SHARING MAY APPLY)		Annual Physical Exam	Covered in Full	Covered in Full
		Screenings & Exams (Preventative PAP/Pelvic, Mammograms, Colorectal, Prostate & Bone Mass Measurement)	Covered in Full	Covered in Full
PHYSICIAN SERVICES		Doctor Office Visit	$15 cost sharing	20% coinsurance
		Specialist Office Visit	$15 cost sharing	20% coinsurance
		X-ray or Radiology	$0 cost sharing	20% coinsurance
		Diagnostic Testing	$0 cost sharing	20% coinsurance
FACILITY SERVICES		Outpatient Surgery	$0 cost sharing	20% coinsurance
		Emergency Room Services (Worldwide Coverage)	$50	$50
		Urgently Needed Care (this is NOT emergency care)	$40	$40
		Inpatient Hospital Stay	$0 per stay	20% coinsurance

PA Turnpike		Freedom Blue PPO w/Rx 178349, 178351, 178356 & 178357	
		In Network	Out Of Network
ADDITIONAL BENEFITS	Skilled Nursing Facility Care (<100 days per Medicare benefit period>)	$0 per day	20% coinsurance
	Annual Routine Vision Exam (Includes refraction)	$0 cost sharing	20% coinsurance
	Eyeglasses or Contact Lenses (<Covered every year>)	Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses.	You have a $100 benefit maximum for out-of-network specialty frames or specialty contact lenses.
	Annual Routine Hearing Exam	$0 cost sharing	20% coinsurance
	Hearing Aids (<covered every three years>)	$500 coverage	$500 coverage
	Chiropractic Office Visits	$15 cost sharing	20% coinsurance
	Home Health	You pay cost sharing of 0% for Medicare-covered home health services	20% coinsurance
	Physical, Speech and Occupational Therapy (per visit/per day/per provider)	$15 cost sharing	20% coinsurance
	Part B Drugs	10% coinsurance/$300 quarterly max	20% coinsurance
	Ambulance (Emergent Services per one way trip)	$25 cost sharing	20% coinsurance
	Durable Medical Equipment (Prosthetics/Orthotics, Diabetic Testing Supplies, Oxygen/Oxygen Supplies)	15% coinsurance	50% coinsurance

PA Turnpike			Freedom Blue PPO w/Rx 178349, 178351, 178356 & 178357	
			In Network	Out Of Network
	MENTAL HEALTH SERVICES	Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)	$0 cost sharing	20% coinsurance
		Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session)	$15 cost sharing	20% coinsurance
	DELUXE SERVICES	Routine Chiropractic & Podiatry	$15 cost sharing	20% coinsurance
		Dental Services (Routine Exam and dental service cost sharing is not applied to the deductible or out of pocket maximums)	$20 cost sharing-office visit $20 cost sharing-Xrays 50% coinsurance for restorative services and dentures	50% coinsurance
DRUGS	PART D DRUGS (<UP TO 31 DAY RETAIL SUPPLY>)	Initial Coverage Period (up to $3,310 in total drug costs)	$15 Preferred Generic $15 Non-Preferred Generic $30 Preferred Brand $60 Non-Preferred Brand $60 Specialty	Not Covered
		Coverage Gap Period (from $3,310.01 in total drug costs to $4,850 in yearly out-of-pocket drug costs)	$15 Preferred Generic $15 Non-Preferred Generic Brands 45% Coinsurance after 50% Discount	Not Covered
		Catastrophic Coverage Period (after $4,850.01 in total out-of-pocket drug costs)	The greater of 5% or $2.95 for generic or multi-source drugs or $7.40 for all other drugs	Not Covered
		Mail Order (up to 90-day supply)	$37.50 Preferred Generic, $37.50 Non Preferred Generic, $75 Preferred Brand, $150 Non Preferred Brand, $150 Specialty	Not Covered

- Diagnostic or outpatient surgery cost sharing may apply for non-screening preventive services.
- Physician office visit cost sharing may apply if a separately billable physician service is rendered.
- Certain categories of Medicare Part B drugs have been excluded from member cost sharing. They include certain vaccines and toxoids, certain miscellaneous drugs and solutions, certain miscellaneous

pathology and laboratory drugs, and certain contrast materials. Prior authorization is necessary for coverage of certain medications. Medicare Part B drugs are not available via retail pharmacy network.

The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Limitations, copayments, and restrictions may apply. Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. You must continue to pay your Medicare Part B premium. Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal.

Questions on Freedom Blue PPO benefits? Call 1-866-456-7739 (TTY users call 711)
Reference Code (Please have this number ready when you call): 16FB8349

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PA Turnpike		Freedom Blue PPO No Rx 178352, 178358, 178354 & 178353	
		In Network	Out Of Network
BASIC PLAN COSTS	Deductible	$0	$0
	Coinsurance	$0	20%
	Out-of-Pocket Maximum	$3400	
PREVENTIVE CARE (OFFICE VISIT COST SHARING MAY APPLY)	Annual Physical Exam	Covered in Full	Covered in Full
	Screenings & Exams (Preventative PAP/Pelvic, Mammograms, Colorectal, Prostate & Bone Mass Measurement)	Covered in Full	Covered in Full
PHYSICIAN SERVICES	Doctor Office Visit	$15 cost sharing	20% coinsurance
	Specialist Office Visit	$15 cost sharing	20% coinsurance
	X-ray or Radiology	$0 cost sharing	20% coinsurance
	Diagnostic Testing	$0 cost sharing	20% coinsurance
FACILITY SERVICES	Outpatient Surgery	$0 cost sharing	20% coinsurance
	Emergency Room Services (Worldwide Coverage)	$50	$50
	Urgently Needed Care (this is NOT emergency care)	$40	$40
	Inpatient Hospital Stay	$0 per stay	20% coinsurance

PA Turnpike		Freedom Blue PPO No Rx 178352, 178358, 178354 & 178353	
		In Network	Out Of Network
ADDITIONAL BENEFITS	Skilled Nursing Facility Care (<100 days per Medicare benefit period>)	$0 per day	20% coinsurance
	Annual Routine Vision Exam (Includes refraction)	$0 cost sharing	20% coinsurance
	Eyeglasses or Contact Lenses (<Covered every year>)	Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses.	You have a $100 benefit maximum for out-of-network specialty frames or specialty contact lenses.
	Annual Routine Hearing Exam	$0 cost sharing	20% coinsurance
	Hearing Aids (<covered every three years>)	$500 coverage	$500 coverage
	Chiropractic Office Visits	$15 cost sharing	20% coinsurance
	Home Health	You pay cost sharing of 0% for Medicare-covered home health services	20% coinsurance
	Physical, Speech and Occupational Therapy (per visit/per day/per provider)	$15 cost sharing	20% coinsurance
	Part B Drugs	10% coinsurance/$300 quarterly max	20% coinsurance
	Ambulance (Emergent Services per one way trip)	$25 cost sharing	20% coinsurance
	Durable Medical Equipment (Prosthetics/Orthotics, Diabetic Testing Supplies, Oxygen/Oxygen Supplies)	15% coinsurance	50% coinsurance

PA Turnpike			Freedom Blue PPO No Rx 178352, 178358, 178354 & 178353	
			In Network	Out Of Network
	MENTAL HEALTH SERVICES	Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)	$0 cost sharing	20% coinsurance
		Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session)	$15 cost sharing	20% coinsurance
	DELUXE SERVICES	Routine Chiropractic & Podiatry	$15 cost sharing	<20% coinsurance>
		Dental Services (Routine Exam and dental service cost sharing is not applied to the deductible or out of pocket maximums)	$20 cost sharing-office visit $20 cost sharing-Xrays 50% coinsurance for restorative services and dentures	50% coinsurance

- Diagnostic or outpatient surgery cost sharing may apply for non-screening preventive services.
- Physician office visit cost sharing may apply if a separately billable physician service is rendered.
- Certain categories of Medicare Part B drugs have been excluded from member cost sharing. They include certain vaccines and toxoids, certain miscellaneous drugs and solutions, certain miscellaneous pathology and laboratory drugs, and certain contrast materials. Prior authorization is necessary for coverage of certain medications. Medicare Part B drugs are not available via retail pharmacy network.

The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Limitations, copayments, and restrictions may apply. Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. You must continue to pay your Medicare Part B premium. Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal.

Questions on Freedom Blue PPO benefits? Call 1-866-456-7739 (TTY users call 711)
Reference Code (Please have this number ready when you call): 16FB8352

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Pennsylvania Turnpike Commission
Aetna Medicare℠ Plan (PPO)
Medicare (P01) PPO
RX $10/$30/$60/$60 Plan

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PLAN FEATURES	Network Providers	Out-of-Network Providers
Combined In and Out of Network Deductible (Plan Level/includes Network Deductible)	$0	$0
Member Coinsurance Applies to all expenses unless otherwise stated.	N/A	15%
Annual Maximum Out-of-Pocket Amount (includes deductible)	$3,400	N/A
Combined Annual Maximum Out-of-Pocket Amount (Plan Level / includes deductible)	N/A	$3,400
Annual Maximum Out-of-pocket Limit amount applies to all medical expenses EXCEPT Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.		
Primary Care Physician Selection	Optional	Not Applicable
There is not a requirement for member pre-certification. If a member fails to obtain pre-certification they will not be denied services or will any penalty amount be applied. However, pre-certification is requested on certain services including inpatient hospital care, inpatient mental health and substance abuse, skilled nursing facility, home health care and some durable medical equipment.		
Referral Requirement	None	None
PREVENTIVE CARE	**Network Providers**	**Out-of-Network Providers**
Annual Wellness Exams One exam every 12 months.	Covered 100%	20%
Routine Physical Exams One exam every 12 months.	Covered 100%	20%
Medicare Covered Immunizations Pneumococcal, Flu, Hepatitis B	Covered 100%	Covered 100%
Routine GYN Care (Cervical and Vaginal Cancer Screenings) One routine GYN visit and pap smear every 24 months.	Covered 100%	20%
Routine Mammograms (Breast Cancer Screening) One baseline mammogram for members 35-39; and one annual mammogram for members age 40 and over.	Covered 100%	20%

Routine Prostate Cancer Screening Exam For covered males age 50 and over every 12 months.	Covered 100%	20%
Routine Colorectal Cancer Screening For all members age 50 and over.	Covered 100%	20%
Routine Bone Mass Measurement One exam every 24 months.	Covered 100%	20%
Additional Medicare Preventive Services* **	Covered 100%	20%
Routine Eye Exams One annual exam every 12 months.	Covered 100%	20%
Routine Hearing Screening One exam every 12 months.	Covered 100%	20%
PHYSICIAN SERVICES	**Network Providers**	**Out-of-Network Providers**
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	$15 copay	20%
Physician Specialist Visits	$15 copay	20%
Allergy Testing	$15 copay	20%
DIAGNOSTIC PROCEDURES	**Network Providers**	**Out-of-Network Providers**
Outpatient Diagnostic Laboratory	Covered 100%	20%
Outpatient Diagnostic X-ray	Covered 100%	20%
Outpatient Diagnostic Testing	Covered 100%	20%
Outpatient Complex Imaging	Covered 100%	20%
EMERGENCY MEDICAL CARE	**Network Providers**	**Out-of-Network Providers**
Urgently Needed Care; Worldwide	$15 copay	$15 copay
Emergency Care; Worldwide (waived if admitted)	$50 copay	$50 copay
Ambulance Services	$25 copay	15%
HOSPITAL CARE	**Network Providers**	**Out-of-Network Providers**

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Inpatient Hospital Care	$0 per stay	20% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery	Covered 100%	20%
MENTAL HEALTH SERVICES	**Network Providers**	**Out-of-Network Providers**
Inpatient Mental Health Care	$0 per stay	20% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Health Care	$15 copay	20%
ALCOHOL/DRUG ABUSE SERVICES	**Network Providers**	**Out-of-Network Providers**
Inpatient Substance Abuse (Detox and Rehab)	$0 per stay	20% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Substance Abuse (Detox and Rehab)	$15 copay	20%
OTHER SERVICES	**Network Providers**	**Out-of-Network Providers**
Skilled Nursing Facility (SNF) Care Limited to 100 days per Medicare benefit period. The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	$0 days 1-100	20%
Home Health Agency Care	Covered 100%	20%
Hospice Care	Covered by Medicare at a Medicare certified hospice.	
Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy)	$15 copay	20%
Cardiac Rehabilitation Services	$15 copay	20%
Chiropractic Services For manipulation of the spine to the extent covered by Medicare.	$15 copay	20%
Durable Medical Equipment/ Prosthetic Devices	15%	20%
Podiatry Services Limited to Medicare covered benefits only.	$15 copay	20%
Diabetic Supplies	Covered 100%	20%
Outpatient Dialysis Treatments	$15 copay	$15 copay
Medicare Part B Prescription Drugs	Covered 100%	20%
Allergy Injections	Covered 100%	20%
ADDITIONAL NON-MEDICARE COVERED SERVICES		

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Healthy Lifestyle Coaching One phone call per week.	Covered
Vision Eyewear Reimbursement	$100 reimbursement every 24 months
Hearing Aid Reimbursement	$500 Once Every 36 Months

PHARMACY - PRESCRIPTION DRUG BENEFITS	
Prescription drug calendar year deductible	$0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.

Pharmacy Network	S2
Formulary	GRP B2 (Four Tier)

Your cost for generic drugs is usually lower than your cost for brand drugs. However, Aetna in some instances combines higher cost generic drugs on brand tiers. Refer to the "Coverage Tier Chart" below to find which drug types are included in each tier of your plan design.

Initial Coverage Limit (ICL)	$3,310 Covered Medicare Prescription Drug Expenditure

The Initial Coverage Limit includes the applicable plan deductible. Until covered Medicare Prescription Drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied), cost-sharing is as follows:

Standard Retail - Member Cost-Sharing up to the Initial Coverage Limit	Member pays $10 for Tier 1 Generic Member pays $30 for Tier 2 Preferred Brand (includes some high-cost generic and preferred generic and non-preferred brand drugs) Member pays $60 for Tier 3 Non-Preferred Brand (includes high-cost non-preferred generic and non-preferred brand drugs) Member pays $60 for Tier 4 Specialty (includes high-cost/unique generic and brand drugs)

Up to one month (30) supply at indicated copay or coinsurance
Three month (90) supply available at retail. When you obtain a 90 day supply at retail, you pay your Preferred Mail Order cost share.

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Preferred Mail Order through Aetna Rx Home Delivery - Member Cost-Sharing up to Initial Coverage Limit	Member pays $20 for Tier 1 Generic Member pays $60 for Tier 2 Preferred Brand (includes some high-cost generic and preferred generic and non-preferred brand drugs) Member pays $120 for Tier 3 Non-Preferred Brand (includes high-cost non-preferred generic and non-preferred brand drugs) Member pays $120 for Tier 4 Specialty (includes high-cost/unique generic and brand drugs)

Up to a three month (90) supply available via our preferred vendor, Aetna Rx Home Delivery.

Coverage Gap**

Once covered Medicare Prescription Drug expenses have reached the Initial Coverage Limit, the Coverage Gap begins. Member cost sharing between the Initial Coverage Limit and until $4,850 in true out-of-pocket costs for Covered Part D drugs is incurred is as follows:

Standard Retail - Member Cost-Sharing during Coverage Gap**	Member pays $10 for Tier 1 Generic Member pays 58% for Generics on Tier 2, Tier 3 and Tier 4 Member pays 45% for Brands on Tier 2, Tier 3 and Tier 4

Member cost share of 45% is the member responsibility after the 50% manufacturer discount is applied.

Up to one month (30 days) supply at indicated copay or coinsurance
Three month (90 days) supply available at retail. When you obtain a 90 day supply at a standard retail pharmacy, you pay your Preferred Mail Order cost share.

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Pennsylvania Turnpike Commission
Aetna Medicare℠ Plan (PPO)
Medicare (P01) PPO
RX $10/$30/$60/$60 Plan

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Preferred Mail Order through Aetna Rx Home Delivery - Member Cost Sharing during Coverage Gap**	Member pays $20 for Tier 1 Generics Member pays 58% for Generics on Tier 2, Tier 3 and Tier 4 Member pays 45% for Brands on Tier 2, Tier 3 and Tier 4

Member cost share of 45% is the member responsibility after the 50% manufacturer discount is applied.

Up to a three month (90) supply available via our preferred vendor, Aetna Rx Home Delivery.

Catastrophic Coverage	Greater of $2.95 or 5% for covered generic (including brand drugs treated as generic) drugs. Greater of $7.40 or 5% for all other covered drugs

Catastrophic Coverage benefits start once $4,850 in true out-of-pocket costs is incurred.

Requirements:	
Precertification	Applies
Step-Therapy	Applies
Non-Part D Drug Rider	Not Covered

Coverage Tier Chart

Tier 1 Generic: includes low-cost generic drugs
Tier 2 Preferred Brand: includes some high-cost generic and preferred brand drugs
Tier 3 Non-Preferred Brand: includes some high-cost non-preferred generic and non-preferred brand drugs
Tier 4 Specialty: includes high-cost/unique brand and generic drugs

*** Additional Medicare preventive services include:

- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use
- Screening and behavioral counseling for alcohol misuse
- Adult depression screening
- Behavioral counseling for and screening to prevent sexually transmitted infections
- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease
- Behavioral therapy for HIV screening
- Hepatitis C Screening

Aetna Medicare is a Medicare Advantage organization with a Medicare contract. Enrollment in Aetna Medicare depends on contract renewal.

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium, and/or copayments/coinsurance may change on January 1 of each year.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Not all health services are covered. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location.

You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.

This material is for informational purposes only and is not medical advice. Not all health services are covered. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Contact a health care professional with any questions or concerns about specific health care needs. See your Evidence of Coverage for a complete description of benefits, exclusions, limitations, and conditions of coverage. Plan features and availability may vary by location and are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna’s preferred drug list. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Pharmacy participation is subject to change.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna is not a provider of health care services and, therefore, cannot guarantee any results or outcomes. Provider participation may change without notice. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. For more information about Aetna plans, go to **www.aetna.com**.

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In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some in- network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

*The Medicare Coverage Gap Discount Program provides a manufacturer discount on brand name drugs to members in a Medicare prescription drug plan. You must have reached the coverage gap and not be receiving Extra Help. Your plan sponsor or former employer provides some additional coverage, during the coverage gap phase, for certain tiers of brand name drugs (depending upon your plan of benefits). For these drugs, you will generally continue to pay the same amount during the coverage gap as you paid in the initial coverage phase. When you obtain other covered brand name drugs that do not qualify for the additional benefit, the pharmacy automatically applies the applicable manufacturer discount when you are billed for your prescription. A 50 percent discount on the negotiated price (excluding a dispensing fee) is available for brand name drugs from manufacturers that have agreed to pay the discount.

Coinsurance is applied against the overall cost of the drug, before any discounts or benefits are applied.

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offering as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for “off label” use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs”. These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

Aetna receives rebates from drug manufacturers that may be considered when determining our preferred drug list. Rebates do not reduce the amount you pay the pharmacy for covered prescriptions. Pharmacy participation is subject to change.

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances when a network pharmacy is not available. If you become ill while traveling in the United States, but are outside of your plan’s service area, you may need to use an out-of-network pharmacy. An additional cost may be charged for drugs received at an out-of-network pharmacy. Quantity limits and restrictions may apply.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24/7
- The Social Security Office at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778**
- Your state Medicaid office

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If you qualify, Medicare could pay for up to 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

This information is available for free in other languages. Please call our customer service number at **1-888-982-3862 (TTY: 711)** for additional information. Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Esta información está disponible en otros idiomas de manera gratuita. Si desea más información, comuníquese con Servicios al Cliente al **1-888-982-3862 (TTY: 711)**. Horario de atención: de Lunes a Viernes, de 8 a.m. a 6 p.m.

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, go to www.aetna.com.

*****This is the end of this plan benefit summary*****

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PLAN FEATURES	Network Providers	Out-of-Network Providers
Combined In and Out of Network Deductible (Plan Level/includes Network Deductible)	$0	$0
Member Coinsurance Applies to all expenses unless otherwise stated.	N/A	15%
Annual Maximum Out-of-Pocket Amount (includes deductible)	$3,400	N/A
Combined Annual Maximum Out-of-Pocket Amount (Plan Level / includes deductible)	N/A	$3,400
Annual Maximum Out-of-pocket Limit amount applies to all medical expenses EXCEPT Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.		
Primary Care Physician Selection	Optional	Not Applicable
There is not a requirement for member pre-certification. If a member fails to obtain pre-certification they will not be denied services or will any penalty amount be applied. However, pre-certification is requested on certain services including inpatient hospital care, inpatient mental health and substance abuse, skilled nursing facility, home health care and some durable medical equipment.		
Referral Requirement	None	None
PREVENTIVE CARE	**Network Providers**	**Out-of-Network Providers**
Annual Wellness Exams One exam every 12 months.	Covered 100%	20%
Routine Physical Exams One exam every 12 months.	Covered 100%	20%
Medicare Covered Immunizations Pneumococcal, Flu, Hepatitis B	Covered 100%	Covered 100%
Routine GYN Care (Cervical and Vaginal Cancer Screenings)	Covered 100%	20%
One routine GYN visit and pap smear every 24 months.		
Routine Mammograms (Breast Cancer Screening)	Covered 100%	20%
One baseline mammogram for members 35-39; and one annual mammogram for members age 40 and over.		
Routine Prostate Cancer Screening Exam	Covered 100%	20%

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For covered males age 50 and over every 12 months.		
Routine Colorectal Cancer Screening For all members age 50 and over.	Covered 100%	20%
Routine Bone Mass Measurement One exam every 24 months.	Covered 100%	20%
Additional Medicare Preventive Services* **	Covered 100%	15%
Routine Eye Exams One annual exam every 12 months.	Covered 100%	20%
Routine Hearing Screening One exam every 12 months.	Covered 100%	20%
PHYSICIAN SERVICES	**Network Providers**	**Out-of-Network Providers**
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	$15 copay	20%
Physician Specialist Visits	$15 copay	20%
Allergy Testing	$15 copay	20%
DIAGNOSTIC PROCEDURES	**Network Providers**	**Out-of-Network Providers**
Outpatient Diagnostic Laboratory	Covered 100%	20%
Outpatient Diagnostic X-ray	Covered 100%	20%
Outpatient Diagnostic Testing	Covered 100%	20%
Outpatient Complex Imaging	Covered 100%	20%
EMERGENCY MEDICAL CARE	**Network Providers**	**Out-of-Network Providers**
Urgently Needed Care; Worldwide	$15 copay	$15 copay
Emergency Care; Worldwide (waived if admitted)	$50 copay	$50 copay
Ambulance Services	$15 copay	15%
HOSPITAL CARE	**Network Providers**	**Out-of-Network Providers**
Inpatient Hospital Care The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	$0 per stay	20% per stay
Outpatient Surgery	Covered 100%	20%

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MENTAL HEALTH SERVICES	Network Providers	Out-of-Network Providers
Inpatient Mental Health Care	$0 per stay	20% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Health Care	$15 copay	20%

ALCOHOL/DRUG ABUSE SERVICES	Network Providers	Out-of-Network Providers
Inpatient Substance Abuse (Detox and Rehab)	$0 per stay	20% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Substance Abuse (Detox and Rehab)	$15 copay	20%

OTHER SERVICES	Network Providers	Out-of-Network Providers
Skilled Nursing Facility (SNF) Care	$0 days 1-100	20%
Limited to 100 days per Medicare benefit period. The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Home Health Agency Care	Covered 100%	20%
Hospice Care	Covered by Medicare at a Medicare certified hospice.	
Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy)	$15 copay	20%
Cardiac Rehabilitation Services	$15 copay	20%
Chiropractic Services For manipulation of the spine to the extent covered by Medicare.	$15 copay	20%
Durable Medical Equipment/ Prosthetic Devices	15%	20%
Podiatry Services Limited to Medicare covered benefits only.	$15 copay	20%
Diabetic Supplies	Covered 100%	20%
Outpatient Dialysis Treatments	$15 copay	$15 copay
Medicare Part B Prescription Drugs	Covered 100%	20%
Allergy Injections	Covered 100%	20%
ADDITIONAL NON-MEDICARE COVERED SERVICES		
Healthy Lifestyle Coaching One phone call per week.	Covered	
Vision Eyewear Reimbursement	$100 reimbursement every 24 months	

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Hearing Aid Reimbursement	$500 Once Every 36 Months

*** Additional Medicare preventive services include:

- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use
- Screening and behavioral counseling for alcohol misuse
- Adult depression screening
- Behavioral counseling for and screening to prevent sexually transmitted infections
- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease
- Behavioral therapy for HIV screening
- Hepatitis C Screening

Aetna Medicare is a Medicare Advantage organization with a Medicare contract. Enrollment in Aetna Medicare depends on contract renewal.

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You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.

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In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some in- network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

This information is available for free in other languages. Please call our customer service number at **1-888-982-3862 (TTY: 711)** for additional information. Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Esta información está disponible en otros idiomas de manera gratuita. Si desea más información, comuníquese con Servicios al Cliente al **1-888-982-3862 (TTY: 711)**. Horario de atención: de Lunes a Viernes, de 8 a.m. a 6 p.m.

Benefits and Premiums are effective January 1, 2016 through
December 31, 2016

National

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, go to www.aetna.com.

*****This is the end of this plan benefit summary*****

Addendum No. 1

RFP # 16-10380-7456

Benefit Consultant

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

QUESTIONS & ANSWERS

Following are the answers to questions submitted in response to the above referenced RFP as of July 18, 2016. All of the questions have been listed verbatim, as received by the Pennsylvania Turnpike Commission.

Proposer Questions			Pennsylvania Turnpike Commission (PTC) RFP #:16-10380-7456		
#	**Page**	**Section**	**Section Description**	**Proposer Question**	**Commission Response**
1	13 of 17	IV-1.a.	Objectives	When was the last time the PTC had all of the programs in question competitively and externally marketed?	The last time was August, 2012 for benefit period January 1, 2013.
2	13 of 17	IV-1.a.	Objectives	Regarding the current PBM arrangement, is the PTC in the midst of a multi-year agreement and if so when may that expire?	The Commission contract will end for medical, prescription, dental and vision December 31, 2017.
3	13 of 17	IV-1.a.	Objectives	Please confirm that all of the rates and fees are net of any professional brokerage / consulting compensation?	Yes, that is correct. Please refer to Appendix G.
4			Dental and Vision	Do retirees get dental and vision?	Management employees who retired after 7/1/1998 has dental and vision coverage.
5			Medical	Is there a need for ongoing reporting (i.e., monthly cost reports, IBNR reports, as well as annual claims review)?	Yes; as part of the optional continuation of services.
6			FSA	Does the Turnpike have an FSA	No.

#	Page	Section	Section Description	Proposer Question	Commission Response
7			Customer Service	Any issues with current vendors.	This information will not be provided.
8	1	I-1	Purpose	What is the primary reason(s) the PA Turnpike Commission has released the current RFP for Employee Benefit Consulting Services?	The Commission is seeking a consultant to provide assistance with the preparation of the benefit RFP, analyze, negotiate and the selection of medical, prescription, dental and vision vendors.
9	1	I-1	Purpose	Who is the current Employee Benefit Consultant for the PA Turnpike Commission?	The Commission does not have a consultant to provide the requested service.
10	1	I-1	Purpose	How long has the PA Turnpike Commission been in contract with the incumbent Consultant? Please include the total number of years, including the time prior to the in-force contract term?	The Commission does not have a consultant to provide the requested service.
11	6	I-25	Indemnification	The RFP indicates that "the indemnification obligation shall not be limited in any way by any limitation on the amount or type of damages, compensation or benefits payable by or for Contractors or its subcontractors." Is this provision negotiable either during or following the finalist selection stage of the RFP process?	The Commission has not received a question on this provision before and thus are not inclined to change it but we are willing to discuss the applicability of this provision.

#	Page	Section	Section Description	Proposer Question	Commission Response
12	13	IV-2	Nature and Scope of the Project	Can the Commission answer any of the following general questions about the RFP: Does the Commission currently utilize a benefits administration system? If so, please describe.	The Commission utilizes the SAP system and sends 834 interface files to each vendor.
				Can you share any details around the current stop loss contract, e.g., Specific deductible, incurred/paid limitations, etc.?	Stop loss is not included in this RFP.
				Can a census be provided, or, at least medical enrollment by plan and tier? If a census can be provided please include: Gender, Date of Birth, home zip code, Medical Plan, Medical Tier, active/retiree indicator	The selected vendor will be provided all relevant information.
				What are the current employee payroll contributions?	Employees pay 5% of the applicable medical tier rate if non-participation in wellness.
				Please describe any ongoing wellness programs and any wellness vendors that are currently utilized.	The Commission utilizes Aetna and Highmark's standard wellness programs.
				Are other ancillary coverages being looked at, e.g., life insurance, disability, voluntary, etc?	The Commission is not soliciting other services.
				Do you expect your consultant to provide actuarial and GASB support?	No.

All other terms, conditions and requirements of the original RFP dated July 1, 2016 remain unchanged unless modified by this Addendum.