REQUEST FOR PROPOSALS FOR

Medical, Prescription Drug, Dental and Vision Benefits

ISSUING OFFICE

Pennsylvania Turnpike Commission
Human Resources Department

RFP NUMBER

17-10380-7710

DATE OF ISSUANCE

February 16, 2017

REQUEST FOR PROPOSALS FOR

Medical, Prescription Drug, Dental and Vision Benefit Plans

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Copies of the appendices listed below will be provided by written request only. Send requests for appendices to vickialfieri@conradsiegel.com. Request must include the Proposer's company name, contact person, email address and the benefits that will be quoted.

PART I

GENERAL INFORMATION FOR PROPOSERS

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

I-2. Issuing Office. This RFP is issued on behalf of the Commission's Human Resources Department through Conrad Siegel Actuaries (CSAct).

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

I-4. Problem Statement. Provide health care benefits and services for the Commission within the guidelines explained in 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 variable-cost contract based on the line of coverage. The Commission may in its sole discretion undertake negotiations with Proposers whose proposals as to price and other factors show them to be qualified, responsible, 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 Commission's 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 vickialfieri@conradsiegel.com with **RFP 17-10380-7710** in the subject line to be received no later than 5:00 PM local time on February 27, 2017. 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 Conrad Siegel Actuaries, Attention: Vicki Alfieri, on or before **2:00 PM** local time on March 10, 2017**. Conrad Siegel Actuaries** is located at 501 Corporate Circle, Harrisburg, PA 17110.

Please note that use of U.S. Mail, FedEx, UPS, or other delivery method, does not guarantee delivery to Conrad Siegel Actuaries by the above listed time for submission. Proposers mailing proposals should allow sufficient delivery time to ensure timely receipt of their proposals. If CSAct 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 CSAct business day on which the office is open. Unless the Proposers are otherwise notified by CSAct, 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 four (4) hard copies of the Technical Submittal, four (4) hard copies of the Diverse Business (DB) participation submittal, and four (4) 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 should be submitted. 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 Conrad Siegel Actuaries (attn. Vicki Alfieri) 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 until at least January 1, 2018. 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) 540-9106) received at CSAct address for proposal delivery prior to the exact hour and date specified for proposal receipt.

Overnight and US Mail Delivery Address:
Conrad Siegel Actuaries
Attn: Vicki Alfieri
501 Corporate Circle
Harrisburg, PA 17110

However, if the Proposer chooses to attempt to provide such written notice by fax transmission, CSAct 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 CSAct 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 contain 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 (January 1, 2018) and will end December 31, 2020, with three (3) two-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. 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-8:
2. Diverse Business Participation Submittal, in response to RFP Part II, Section II-9; and
3. Cost Submittal, in response to RFP Part II, Section II-10:

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. 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: Medical, Prescription Drug, Dental or Vision Benefit, RFP 17-10380-7710. 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.

II-2. Statement of the Problem. State in succinct terms your understanding of the problem presented or the service required by this RFP.

II-3. Management Summary. Include a narrative description of the proposed effort and a list of the items to be delivered or services to be provided.

II-4. Work Plan. Provide a brief history and description of your firm's business organization and its experience in medical, prescription drug, dental, and/or vision insurance benefit service expertise and experience as it relates to the requirements discussed in Part IV through Part VIII of this RFP.

II-5. Prior Experience. Include experience in medical, prescription drug, dental, and/or vision health insurance benefits. Experience shown should be work done by individuals who will be assigned to this project as well as that of your company. Studies or projects referred to should be identified and the name of the customer shown, including the name, address, and telephone number of the responsible official of the customer, company, or agency who may be contacted.

II-6. Personnel. Include the number, and names where practicable, of executive and professional personnel, analysts, auditors, researchers, programmers, consultants, etc., who will be engaged in the work. Show where these personnel will be physically located during the time they are engaged in the work. Include through a resume or similar document, education and experience in medical, prescription drug, dental, and/or vision health insurance benefits. Indicate the responsibilities each will have in this project and how long each has been with your company. Identify subcontractors you intend to use and the services they will perform.

II-7. Training. If appropriate, indicate recommended training of Commission personnel (i.e. vendor systems, enrollment, etc.).

II-8. Technical Submittal – Questionnaires for Vendors which shall be a response to Part V (Technical) for Medical, Part VI (Technical) for Prescription Drug, Part VII (Technical) for Dental and Part VIII (Technical) for Vision.

II-9. 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-10. 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 or Flash Drive, 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 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.

Cost submittal should be submitted using the Questionnaire for Vendors Financial Response sections in Part V through Part VIII for Medical, Prescription Drug, Dental and Vision.

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 Conrad Siegel Actuaries (CSAct) Team of qualified personnel based on the evaluation criteria listed below. CSAct will present the evaluations to the Professional Services Procurement Committee (PSPC). The PSPC will review the CSAct 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 firms for the assignment or the firm whose proposal is determined to be most advantageous to the Commission by considering CSAct'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:

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

b. Proposer Qualifications. This refers to the ability of the Proposer to meet the terms of the RFP, especially providing medical, prescription drug, dental, and or vision health insurance benefit services, as it relates to the requirements/questionnaires in Part IV through Part VIII of this RFP. This also includes the Proposer's financial ability to undertake a project of this size. Responses of references, if CSAct elects to solicit them, and the responsiveness, organization, and clarity of submitted proposal will also be considered.

c. 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.

d. Personnel Qualifications. This includes 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 the type of experience. Particular emphasis is placed on the qualifications of the day to day project manager.

e. Commitment to Diversity and Inclusion. This refers to the inclusion of DB firms, as described in Part II-9. 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 soliciting proposals from qualified vendors to provide medical, prescription drug, dental, and vision health insurance benefits to its eligible employees, retirees, and their family members.

b. Specific. The Commission is soliciting competitive proposals to reduce health care costs, provide high-quality service, and to effectively manage and control claim information for the following health insurance benefit plans: medical, prescription drug, dental, and vision. The term of the contract will commence on January 1, 2018, and will end on December 31, 2020, with three (3) two-year renewal options. The contract should contain no termination penalty if the Commission desires to terminate the contract early.

IV-2. Nature and Scope of the Project.

Vendors responding to the proposal will need to designate the categories they are submitting for qualification from the following list. Vendors may submit a proposal for one category or for several categories.

1. Medical Plan
2. Prescription Drug Plan
3. Dental Plan
4. Vision Plan

a. Background - The Commission is an independent agency of the Commonwealth of Pennsylvania. As a government agency, the Commission is not governed by the rules, regulations, or legislative requirements of ERISA. The PA Turnpike is a key transportation route within the state of Pennsylvania and a vital link in the network of the eastern United States. The Turnpike is 536 miles in length with 60 fare collection facilities, 20 service plazas and two welcome centers, 21 maintenance buildings, 8 police barracks, and 5 tunnels (www.paturnpike.com).

As of February 2017, there were approximately 450 non-union and 1,650 union employees of the Commission who work in over 110 locations including three administrative offices: the Central Administration Office in Middletown, PA, the Eastern Regional Office in King of Prussia, PA, and the Western Regional Office in New Stanton, PA. There are also approximately 1,000 retirees of the Commission on benefits.

b. Scope - The Commission provides medical and prescription benefit plans to approximately 3,900 employees and retirees, and additionally to their eligible family members. The Commission offers three (3) different medical plans for active employees and retirees under the age of 65: (1) a PPO plan that covers the whole state, (2) a PPO plan that covers Western Pennsylvania, and (3) an Affordable Care Act qualifying plan for part-time employees. For age-65-and over retirees the following three (3) plans are offered: a signature 65 retiree Medicare wrap-around plan and two (2) PPO Medicare Advantage plans. 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 and management groups. Additionally, the Commission offers one dental plan and one vision plan, both of which are available only to Management and Local 30 Supervisory employees and retirees. The administration of COBRA continuation coverage is also included in this RFP. The Commission will be utilizing the services of Conrad Siegel Actuaries for the review and analysis of proposals received in response to this RFP.

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IV-3. Requirements. Proposer must be able to complete the requirements 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.

Please be sure to carefully review this information prior to composing your response.

A. General Plan Information

Most of the current benefit plans/carriers have been in place since March 1, 2008, with agreements ending December 31, 2017. All benefit options listed below are self-insured (with the exception of the Highmark Blue Shield Freedom Blue Plan and the Aetna PPO Medicare Advantage Plan) and are provided on a calendar-year basis. Current administrative fees, policies, and agreements will not be provided. Employees, participating in the wellness plan and under-age-65 retirees do not currently pay any premium contributions for the plans. Employees not participating in the wellness plan are responsible for 5% of the tiered budget rates. Union retirees pay a portion of their age 65 and over coverage. Management/Local 30S employees are eligible on the first of the month following their hire date. Union employees are eligible on 91st day of employment. Benefit plans included in this RFP include the following:

- Medical – through Highmark Blue Shield
  - Applies to union and management employees and retirees.
  - Four plans:
    - Active and Pre-65 Retirees - PPO Plan for the whole state (2,370 contracts)
    - Active - an Affordable Care Act Plan (7 contracts)
    - Post-65 Retirees - a Freedom Blue Medical Plan (360 contracts)
    - Post-65 Retirees - a Signature 65 Medicare wrap-around plan (915 contracts)
  - There is a wellness program in place for the PPO plan.

- Medical – through Aetna Life Insurance Company
  - Applies to union and management employees and retirees.
  - Two plans:
    - Active and Pre-65 Retirees - PPO Plan for Western PA only (250 contracts)
    - Post-65 Retirees - PPO Medicare Advantage plan. (15 contracts)
  - There is a wellness program in place for the Western PA PPO plan.

- Prescription Drug – through Aetna Life Insurance Company
  - Applies to management and union employees and retirees.
  - Three plans:
    - An active employee plan, (1900 contracts)
    - a retiree plan for retirees under age 65, and (530 contracts)
    - a retiree plan for retirees age 65 or over. (915 contracts)

- Dental – through United Concordia Companies, Inc.
  - Applies to Management/Local 30S employees and retirees. Union employees are covered through the Teamster's Health and Welfare Fund, and are not included in this portion of the RFP. (840 contracts)
  - Same Plan design for both active employees and retirees, regardless of age.

- Vision – through Highmark Blue Shield, with Davis Vision
  - Applies to management/Local 30S employees and retirees. (855 contracts)
  - Union employees are covered through the Teamster's Health and Welfare Fund, and are not included in this portion of the RFP.
  - Same Plan design for both active employees and retirees, regardless of age.

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

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

Proposer should quote all programs using the assumption that they may not be awarded all of the programs and may in fact be one of many carriers providing services to the Commission.

If the submitted proposal includes more than one benefit coverage (i.e. includes both medical and prescription drug, or medical and vision, etc.), please clearly identify any changes or variances that would apply to the proposal if awarded only one of the benefit coverages presented.

Additionally, please clearly identify any changes or variances that would apply to the proposal if multiple vendors are awarded the same line of benefit coverage (i.e. two vendors for the same line of coverage may be selected due to coverage areas, network, etc.).

B. Program Eligibility

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

a. A contract holder's spouse/domestic partner.
b. Children under 26 years of age, including:
   1. Newborn children. A newborn child of a member will be considered a dependent under this program for 31 days immediately following birth. If the member wishes to continue coverage for the newborn beyond that date, the infant must be enrolled for coverage
   2. Stepchildren.
   3. Legally adopted children of the contract holder or the spouse. An adopted child is considered acquired on the date when the member takes active or constructive possession of the child.
   4. Children legally placed for adoption.
   5. Employee/retiree has obtained legal custody of the child in accordance with a court order signed by a judge.
   6. Employee/retiree is responsible for the sole support of the child as a result of the death of his/her parents.

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

C. Financing

All plans should be quoted on a self-insured basis (with the exception of the Medicare Advantage Plans). For self-insured proposals, please outline the different financial methods you can offer to accomplish a self-insured plan.

All future benefit plan renewals are to be effective January 1st and should include a minimum 120-day notice of annual renewal, which include COBRA rates.

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

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

D. **Time Line***

Item Description	Due Date
RFP available	**February 16, 2017**
Questions due from vendors	**February 27, 2017**
Proposals due from vendors	**March 10, 2017**
Vendor presentations (finalists only)	**Week of March 27**
Provider award/approval	**May 1, 2017**
Implementation	**May – September 2017**
Effective date of contracts	**January 1, 2018**

***Any changes to the above time line will be at the discretion of the Commission.**

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

A. Administrative Requirements

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

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

3) The Commission will reserve the right to audit, either directly or through its authorized agent(s), the vendor's compliance with the terms of the contract. Upon providing appropriate assurance as to compliance with HIPAA and other relevant privacy standards, the vendor will agree to provide the Commission or its authorized agent(s) with the data needed to perform these audits or reviews. If any costs are associated with audits, please include cost in the responses to the financial section

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

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

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

5) Proposer will demonstrate adoption of arrangements to protect the Commission and its affiliates and plan participants from incurring liability for payment of any fees which are your legal obligation, including but not limited to (i) sufficient insolvency and liability insurance, (ii) a contractual arrangement with medical providers affiliated with you that prohibits such providers from holding any participant liable for payment of any fees which are your obligation, and (iii) other protection from liability for participants as provided by applicable state or federal laws.

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

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

8) Proposers must be able to receive an electronic data interface in the HIPAA-compliant 834 interface format.

9) The Proposer agrees to assist the Commission with evaluating any claim contested as a result of bargaining agreement grievances/arbitrations and will adjudicate claims in compliance with grievance settlements and arbitration awards.

B. Financial Requirements

1) Rates are guaranteed for a minimum of twelve (12) months, beginning January 1, 2018. Future rates will be guaranteed for a minimum of twelve (12) months.

2) Rates provided (for fully-insured products (Medicare Advantage Plans Only), or for COBRA rates for self-insured products) will be a five (5) tier rate structure and a composite rate.

3) Annual rate renewals must be provided by September 1 for January 1 rate changes.

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

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

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

C. Administrative Service Expectations and Performance Guarantee

The Commission expects the Proposer health insurance benefit plan to provide premium service in administering benefits to Commission employees/retirees. To help accomplish that goal, the Commission expects the plan to guarantee that the following administrative functions will be performed in a consistent and timely manner.

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

2) The Proposer must have the ability to cease/suspend payment of claims and terminate eligibility en masse as frequently as on a daily basis in the event of union strikes.

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

4) Claims reports, upon request, must be able to: break out Commission management and union benefits; show utilization by age/sex, employee/family member status, and type of service; show enrollment info for specific time periods; and show benefit category by claim amount. Reports must comply with HIPAA regulations and cannot disclose Protected Health Information of employees unless exclusively requested by the Commission or agent acting on the Commission's behalf.

5) For a self-funded arrangement, the Proposer agrees to provide monthly individual claims data.

6) Proposer must be able to support several group numbers and multiple benefit plan designs for both active employees and retirees at no additional charge. The Commission has different group numbers for different groups of employees and retirees for budgeting purposes.

7) Proposer must be able to produce a customized handbook, customized ID cards, plan summary sheet, and delivery of handbooks no later than the date of plan implementation.

8) Proposer must provide dedicated customer service representatives with a dedicated toll free telephone number to answer questions for employees, retirees, and the Human Resources department of the Commission.

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

D. Acceptance of Requirements

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

_____ Without exception

_____ With exceptions described below

Exceptions:

Insurer or Plan Administrator: _____

Location: _____

Officer's Signature: _____

Officer's Printed Name: _____

Title: _____

Date: _____

PART V

QUESTIONNAIRE FOR VENDORS – MEDICAL (Technical Response)

This section applies only to the Medical Program. Only vendors submitting proposals for the Medical Program should respond to this section.

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

A. Company Background

1. Years in group benefit plan administration
2. Products offered
3. Area/Markets served (including counties)
4. Number of total groups
5. Number of groups with over 3,000 lives covered
6. Number of members covered
7. Number of employees
8. Any Subsidiaries and/or Affiliates
9. Company financial information and ratings
10. Future plans for group benefit plan administration (i.e. where you see your organization going in the next five years; network development, contracting approaches, other changes, etc.)
11. Explain what differentiates you from your competitors

B. Access/Network

1. Describe your national network service area.

2. How many networks can you offer to the Commission? Please include information (if applicable) regarding each network including the following:
    a. Year network organized
    b. Type (PPO, POS, Indemnity, etc.)
    c. Organization's relationship to network (i.e., owned, affiliated, etc.)
    d. Current number of Hospitals, Ancillary facilities, PCP's, and Specialists under contract
    e. Number of the above that are JCAHO-accredited or board certified
    f. Number of Hospitals, Ancillary facilities, PCP's, and Specialists in network in each of the past 3 years
    g. Number of Hospitals, Ancillary facilities, PCP's, and Specialists in market area
    h. Length of Contract (Hospital, Ancillary facilities, PCP, and Specialist)
    i. Length of Termination Notice (Hospital, Ancillary facilities, PCP, and Specialist)
    j. Percentage (%) of providers that participate in market area

3. Provide a GeoAccess report using the standards defined below and the employee residence zip code data provided on the census.
    - Two primary care physicians within 8 miles of an employee's zip code.
    - Two specialty physicians within 8 miles of an employee's zip code. Include all specialties. Be sure to include a list of the types of specialties.
    - One hospital within 10 miles of an employee's zip code

4. Complete a network disruption analysis using the top 500 providers for both physicians and facilities.

5. Describe how you recruit new providers and facilities.

6. Advise of your willingness and capability to develop networks in locations where you do not now have acceptable access. Under what conditions would you do so? What would be the time frame?

7. Describe the process that allows the Commission and its employees to recommend providers for addition to the network.

8. Complete the following chart to indicate provider activity in your networks.

Provider Activity	Vendor Response
Number of large physician group contracts that will expire within the next 12, 24, or 36 months. (Please identify)	
Number of hospital contracts that will expire within the next 12, 24, or 36 months. (Please identify)	
Number of physicians involuntarily terminated in 2014, 2015, and 2016	
% of PCP accepting new patients	
Provider turnover rate for 2014, 2015, & 2016	
Facility turnover rate for 2014, 2015, & 2016	

9. Do you expect any difficulty with renegotiating any expiring contracts for large physician groups and hospitals? If so, what contingency plans are in place?

10. Do you have psychiatric/substance abuse providers in your networks, or are the services subcontracted through another network of providers? If subcontracted, are there contracts for these subcontractors?

11. Please provide an internet and telephone resource for network participation information.

12. For in-network providers, provide details on your provider-negotiated contracts (specify percentage (%) difference between negotiated amounts vs. charges). Provide the basis for your in-network reimbursement levels and your definition of "reasonable and customary" charge.

13. Explain in detail how members residing outside of your service area would be covered and how their benefits will be administered.

14. Explain how a member would access your network while traveling, both in the United States and abroad.

15. Please explain how emergencies are paid at an out-of-network provider, and if there will be any balance bill to the participant.

16. Does the out-of-network allowance differ based on the state?

17. If applicable, explain the network used for a telehealth benefit.

18. Regarding an emergency service for an out-of-network provider, once the participant is stabilized, please explain the continuation of care process.

19. Explain how the employee and employer are notified of provider changes, network changes, and coverage changes. Will the Commission be able to opt out of changes that violate union-negotiated benefits?

20. What are the financial arrangements if a provider terminates his or her contract with your organization in the middle of the course of treatment of a patient?

21. How do you assess member satisfaction in your networks? How often do you conduct this assessment? To whom are the results made available? Please provide specifics on how this is tested, with current results.

C. Customer Service

1. Complete the chart below to provide information on your organization's customer service.

Customer Service Area	Vendor Response
Average hold time in seconds and average abandonment rate for calls in 2015 and 2016	
Hours of operation of customer service unit	
Will there be a dedicated toll-free customer service unit for the Commission's employees and retirees?	
Will there be a dedicated toll-free customer service unit for the Commission Human Resources Department?	
Number of customer service representatives assigned to the Commission service unit	
Average length of service of the customer service representatives	
Customer service employee turnover rate for 2015 and 2016	
Member satisfaction rating in most recent member satisfaction survey	

2. Describe the training process for your customer service representatives.

3. Are any of your customer service functions outsourced? If yes, please list.

4. Does your organization perform client specific customer service satisfaction surveys? If yes, how frequently and what guidelines are followed?

5. Outline the procedure an employee is to follow if a satisfactory resolution is not received from your customer service staff.

6. Who would be the primary individual (Account Executive) responsible for maintaining and updating all group information through the year and working directly with the Commission? Please include name, experience, years with vendor, professional biography, and number and size of other clients they are currently servicing.

7. Who would be the individual (Account Executive backup) that would be available in the absence of the above-named Account Executive? Please include name, experience, years with vendor, professional biography, and number and size of other clients they are currently servicing.

8. Advise on your willingness to attend Commission-sponsored open enrollment meetings or seminars.

9. Do you provide group-level and member-level newsletters or other publications? On what topics? Please provide samples.

10. Indicate your willingness to participate in health benefits fairs at multiple locations in-state, and discuss activities you can present such as blood pressure screening, body fat analysis, etc.

D. Program Administration

1. Describe in detail your Claims Appeal process including the names of the companies you contract with to conduct the external review?

2. Describe the system edits, procedures, and internal and external audit processes used to ensure that only medically necessary claims and valid claims based on plan provisions are paid by the plan.

3. Describe the process for ensuring that this plan and the Commission are in compliance with all applicable laws.

4. Describe any current or pending legal actions in which your organization may be involved.

5. What liability insurance limits do you have for individual protection?

6. Are any of your claims administration functions outsourced? If yes, please list.

7. Are any of your claims administered outside of the United States? Is yes, please provide details.

8. Complete the chart below to provide information on your organization's claims administration.

Claims Administration Area	Vendor's Response
Turnaround time of claim payments to network providers	
Turnaround time of claim payments to network facilities	
Turnaround time of claim payments to out-of-network providers	
Turnaround time of claim payments to out-of-network facilities	
Turnaround time of claim payments to employees	
Turnaround time to the Commission for claims paid in error	
Coding accuracy for 2015 and 2016	
Financial accuracy for 2015 and 2016	

9. Please describe in detail the reports that are available to the Commission. How much customization is available?

10. Are these reports available in real-time and on-line via the Internet?

11. Are ad hoc reports available to the Commission? If yes, and if there is a charge for these reports, please include only in the financial section.

12. Are you able to provide the Commission with reports of Medicare eligible members? How often?

13. Please confirm your willingness to provide a comprehensive ASO reporting package including individual claims data and enrollment on a monthly basis. Will there be any additional cost associated with data reporting, including any potential reporting for purposes of government programs? If yes, please include only in the financial section.

14. Please describe your billing procedures. Is electronic billing available? Please describe your electronic billing capabilities including invoices, reports, and payments. Is a detailed bill available each month?

15. Under an ASO arrangement, will the vendor provide rating and underwriting support, including but not limited to rating trends, plan design cost relativities, and recommended COBRA and funding rates? Are any additional fees applicable? If yes, please include only in the financial section.

16. Describe how your organization will handle/provide the required reporting for the Summary of Benefits and Coverage requirement. How will your organization handle the Summary of Benefits and Coverage if the Prescription Drug is covered under another vendor? If there are costs involved, please include cost in the financial section.

17. Describe your compliance with HIPAA. Include in your response details on your organization's policies on privacy, security (including physical safeguards), electronic data interchange requirements, and HiTech.

18. Describe your capabilities as they relate to the Administrative Simplification provisions of HIPAA. Are you capable of processing enrollment and record changes in accordance with HIPAA requirements?

19. As it relates to HIPAA HiTech, has your company had any breaches?

20. Is your organization currently in any discussions to be purchased by another organization, to purchase another organization, or to merge with another organization? If yes, provide details.

21. Advise if there will be any major system changes that could affect enrollment or claims in the next 12-24 months, and how you will ensure minimal disruption to the participant and the Commission.

22. Indicate tools or applications available through your organization for the purposes of improving quality and engaging consumers.

23. Does your organization support incentives for high-value health care? Please describe in detail.

24. Explain if coverage is offered for diabetic supplies and how a member would obtain them.

25. Describe the following programs/procedures that are included in your proposal, and how a member would access these programs:
    - Large case management (high dollar cases)
    - Case management
    - Disease management
    - New programs in development?

    Include in your response answers to the following questions:
    - How do you identify cases for case management?
    - What are the credentials of your case managers?
    - How would you educate employees and retirees as to the services offered through case management?
    - Describe any disease state and large claim management programs and reporting processes.

26. Describe utilization review conducted on providers and facilities, and describe the qualifications of your utilization management staff. What is the process of handling unacceptable patterns of behavior? What results have been achieved through utilization management?

27. Do you require pre-certification for any procedures or diagnostic services? If yes, list criteria and procedures and describe the pre-certification process. How is the pre-certification program coordinated with other utilization management programs, such as chronic case management or large case management?

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

29. Describe how you will handle ongoing transition of care in the following situations where:
    a. An eligible member is receiving treatment on the effective date of coverage
    b. Member is hospitalized
    c. Member is receiving major ongoing treatment (not hospitalized) for an acute condition
    d. Member is receiving major ongoing chronic care requiring specialized management
    e. Member is receiving non-acute ongoing care
    f. Member is pregnant
    g. Member is receiving ongoing treatment for outpatient mental health or substance abuse
    h. Member is receiving ongoing treatment for any of the above conditions with a non-participating provider (continuity of care)

30. Describe the process for certifying a disabled dependent.

31. Are network, customer service notes, and utilization management information integrated with claims system?

32. Describe your means for obtaining Coordination of Benefits (COB) info, and COB procedures for in-network and out-of-network claims. How do you determine COB savings for Medicare eligibles? For non-Medicare eligibles? How often is this information updated?

33. Describe your experience with the Systems, Applications and Products in Data Processing (SAP) system and confirm your ability to interface with SAP.

34. Describe in detail any wellness programs that are available and how an employee would access these programs. Please include any additional costs if applicable in cost section.

35. Please advise on your willingness to conduct on-site wellness screenings and testing. If yes, and there is a charge, please include only in the financial section.

36. Please provide details regarding value-added services such as wellness discounts, vision and dental benefits, and include any associated costs in the financial section.

E. Website Features

1. Describe your electronic capabilities with respect to electronic and/or online enrollment, maintenance of eligibility records, and access to electronic reports.

2. Describe your employee internet capabilities with respect to online directories, access to claims, view/change enrollment data, and ability to order and print ID cards, and other services available to members of the Commission. Be sure to include information on online consumer tools.

3. Describe your employer internet capabilities with respect to online directories, access to claims, view/change enrollment data, and ability to order and print ID cards, and other services available to Human Resources personnel of the Commission.

4. List services available to members on your website and provide a screen shot that shows how EOB and claim history are displayed.

F. Implementation

1. Provide a detailed implementation time line identifying each task and target date for a January 1, 2018, effective date. Be sure to include plan setup and 834 interfacing.

2. Describe your experience with 834 interfacing.

3. Would you be willing to conduct a site visit and/or claims office visit for designated members of the Commission?

G. References

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

2. Provide three references of former employer groups of similar size and scope. Include how long each was a customer and the approximate number of employees.

H. Sample Documents Requested

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

QUESTIONNAIRE FOR VENDORS – MEDICAL (Financial Response)

This section applies only to the Medical Program. Only vendors submitting proposals for the Medical Program should respond to this section.

All cost information must be separate from the technical portion of the proposal.

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

1. Self-funded (ASO) arrangement - Provide a PCPM administration fee for an effective date of January 1, 2018. Provide a 3-year rate guarantee. In addition, please provide three (3) additional two (2) year terms for a total of nine (9) years.

2. Self-funded (ASO) arrangement - Provide a percent of claims administrative fee option for an effective date of January 1, 2018. Provide a 3-year rate guarantee. In addition, please provide three (3) additional two (2) year terms for a total of nine (9) years.

3. Self-funded (ASO) arrangement - Please provide budget rates and details of the budget rate development. Please use the rate relativities listed below:

   Actives and Pre-65 Retirees

Single	1.00
EE/Spouse	2.25
Parent/Child	1.70
Parent/Children	2.63
Family	2.90
Composite	

4. Under an ASO funding arrangement, is an advance deposit, cash advance, or letter of credit required? If so, how is the initial amount determined? How is each subsequent year determined?

5. Are there any payment options available that would eliminate the need for an advance deposit, cash advance, or letter of credit (i.e., weekly billing)?

6. Under an ASO funding arrangement, is there an administrative expense for processing run-out claims should there be a desire to return to a fully-insured program or switch to another self-funded administrator?

7. For in-network providers, please provide details on your provider-negotiated contracts (specify percentage difference between negotiated amounts vs. charges). Provide the basis for your in-network reimbursement levels. For out-of-network providers, please provide your definition of “reasonable and customary” charge as a percentage of Medicare reimbursement level.

In addition, please provide the average per-service cost for the listed services provided in the following zip codes:

Procedure Code	Description	Zip Code 15537	Zip Code 17111	Zip Code 18235	Zip Code 15601	Zip Code 17042	Zip Code 16101
99213	OFFICE/OUTPATIENT VISIT EST						
99214	OFFICE/OUTPATIENT VISIT EST						
97110	THERAPEUTIC EXERCISES						
97140	MANUAL THERAPY						
36415	ROUTINE VENIPUNCTURE						
98941	CHIROPRACTIC MANIPULATION						
97014	ELECTRIC STIMULATION THERAPY						
90837	PSYTX PT&/FAMILY 60 MINUTES						
99203	OFFICE/OUTPATIENT VISIT NEW						
90471	IMMUNIZATION ADMIN						
99212	OFFICE/OUTPATIENT VISIT EST						
98943	CHIROPRACTIC MANIPULATION						
S9088	SERVICES PROVIDED IN URGENT						
97012	MECHANICAL TRACTION THERAPY						
80061	LIPID PANEL						
98940	CHIROPRACTIC MANIPULATION						
95117	IMMUNOTHERAPY INJECTIONS						
99232	SUBSEQUENT HOSPITAL CARE						
88305	TISSUE EXAM BY PATHOLOGIST						
A7038	POS AIRWAY PRESSURE FILTER						
80053	COMPREHEN METABOLIC PANEL						
97112	NEUROMUSCULAR REEDUCATION						
93010	ELECTROCARDIOGRAM REPORT						
97035	ULTRASOUND THERAPY						
85025	COMPLETE CBC W/AUTO DIFF WBC						
71020	CHEST X-RAY						
S0612	ANNUAL GYNECOLOGICAL EXAMINA						
83036	GLYCOSYLATED HEMOGLOBIN TEST						
90834	PSYTX PT&/FAMILY 45 MINUTES						
90686	FLU VAC NO PRSV 4 VAL 3 YRS+						
77052	COMP SCREEN MAMMOGRAM ADD-ON						
99204	OFFICE/OUTPATIENT VISIT NEW						
G0202	SCREENINGMAMMOGRAPHYDIGITAL						
90460	IM ADMIN 1ST/ONLY COMPONENT						
99396	PREV VISIT EST AGE 40-64						
20610	DRAIN/INJECT JOINT/BURSA						
99215	OFFICE/OUTPATIENT VISIT EST						
96372	THER/PROPH/DIAG INJ SC/IM						
93000	ELECTROCARDIOGRAM COMPLETE						
99202	OFFICE/OUTPATIENT VISIT NEW						
99285	EMERGENCY DEPT VISIT						
87880	STREP A ASSAY W/OPTIC						
99284	EMERGENCY DEPT VISIT						

Procedure Code	Description	Zip Code 15537	Zip Code 17111	Zip Code 18235	Zip Code 15601	Zip Code 17042	Zip Code 16101
A4253	BLOOD GLUCOSE/REAGENT STRIPS						
G0283	ELEC STIM OTHER THAN WOUND						
99244	OFFICE CONSULTATION						
80050	GENERAL HEALTH PANEL						
00810	ANESTH LOW INTESTINE SCOPE						
97530	THERAPEUTIC ACTIVITIES						
99283	EMERGENCY DEPT VISIT						

8. What percentile of reasonable and customary (R&C) do you use? How often do you update R&C? What is the source of data used to establish R&C?

9. What R&C amount do you use for out-of-network claims that are paid out-of-state?

10. Are there any access fees (i.e., network fees) that you are required to pay to other carriers? If so, please explain in detail and provide fees.

11. Are there any OON fees that you would require the Commission to pay for? Such as a fee for savings on a OON claim? Physician Value Reimbursement Program?

12. How often do you negotiate contracts with in-network service providers?

13. Please provide the average hospital and physician discounts as of January 2017 for hospitals and physicians in the following Pennsylvania counties:

	Hospital	Physician
Allegheny		
Beaver		
Bedford		
Berks		
Bucks		
Carbon		
Chester		
Cumberland		
Dauphin		
Delaware		
Fayette		
Franklin		
Fulton		
Huntingdon		
Lancaster		
Lackawanna		
Lawrence		
Lebanon		
Lehigh		
Luzerne		
Montgomery		
Perry		
Philadelphia		
Schuylkill		
Somerset		
Westmoreland		

14. Performance Guarantees—Provide performance guarantees tied to plan implementation (first year only), member satisfaction, reporting/recordkeeping, quality assurance, and account management. Complete the chart below to propose your performance measures and amount of fee at risk. Please be sure to include the following: claims turnaround, accuracy of claim payment, customer service problem resolution, timely issuance and accuracy of identification cards, employee benefit booklets, and program contracts.

	Vendor's Response
Plan implementation (first year only)	
Performance standard	
Performance guarantees	
Percent of fee at risk	
Member Satisfaction	
Performance standard	
Performance guarantees	
Percent of fee at risk	
Reporting/Recordkeeping	
Performance standard	

Performance guarantees	
Percent of fee at risk	
Quality Assurance	
Performance standard	
Performance guarantees	
Percent of fee at risk	
Account Management	
Performance standard	
Performance guarantees	
Percent of fee at risk	

15. Please provide details on your "other party liability" functions including documentation of quantifiable savings.

16. Please provide details on your subrogation functions including documentation of quantifiable savings.

17. What is the cost of Medical Case Management and the expected future cost savings? What are the savings that you guarantee?

18. In the quotes that you have provided, are there any disease management or wellness programs included? If so, please describe.

19. Please detail any administrative expense that is not included as part of the claim administration fee/retention. Examples of expenses include ad hoc reports, ID cards, summary books, and open enrollment meetings.

20. Please list the percentage of eligible employees that must be enrolled under your group plans. Does that change if more than one vendor for the same line of coverage is awarded a contract?

21. The Commission currently utilizes Avalon as their Stop Loss Carrier. Please describe your willingness to work with Avalon. Also describe what your process would be in communicating with Avalon.

22. Do you offer COBRA administration and/or retiree billing services? If so, please provide a menu of your COBRA and retiree billing services and all costs associated with these services.

23. Please explain any additional claim charges beyond the incurred charge that would be applied to the plan. Examples include: Pay for Performance, Value Based Reimbursement Program, True Performance, etc.

PART VI

QUESTIONNAIRE FOR VENDORS – PRESCRIPTION DRUG (Technical Response)

This section applies only to the Prescription Drug Program. Only vendors submitting proposals for the Prescription Drug Program should respond to this section.

A. Company Background

1. Years in group benefit plan administration
2. Products offered
3. Area/Markets served (including counties)
4. Number of total groups
5. Number of groups with over 3,000 lives covered
6. Number of members covered
7. Number of employees
8. Any subsidiaries and/or affiliates
9. Company financial information and ratings
10. Future plans for group benefit plan administration (i.e. where you see your organization going in the next five years; network development, contracting approaches, other changes, etc.)
11. Explain what differentiates you from your competitors

B. Access/Network

1. Please describe your retail pharmacy network including the number of pharmacies in Pennsylvania, the number outside of Pennsylvania, and the percentage of pharmacies that participate.

2. Please list the major pharmacy chains that participate in your network, and list any major pharmacy chains that do not participate in your network.

3. Provide details on your exclusive Specialty Provider.

4. Describe your national network service area. Is your network accessible to members traveling abroad?

5. Explain how a member would access your network while traveling, both in the United States and abroad.

6. Provide a GeoAccess study using the standards defined below and the employee residence zip code data provided on the census.
   - Total number of network pharmacies within: 1 Mile, 3 Miles, 10 Miles

7. Complete a network disruption analysis using the top 100 pharmacies.

8. Describe how you recruit new pharmacies to the network.

9. Advise of your willingness and capability to develop networks in locations where you do not now have acceptable access. Under what conditions would you do so? What would be the time frame?

10. Describe the process that allows the Commission and its employees to recommend pharmacies for addition to the network.

11. What is the number of pharmacies that were involuntarily terminated in 2014, 2015, and 2016?

12. Please provide an internet and telephone resource for network participation information.

13. Explain in detail how members residing outside of your service area would be covered and how their benefits will be administered.

14. Explain how the employee and employer are notified of pharmacy, network changes, and coverage changes. Will the Commission be able to opt out of changes that violate union-negotiated benefits?

15. How do you assess member satisfaction in your networks? How often do you conduct this assessment? To whom are the results made available? Please provide specifics on how this is tested, with current results.

16. List the location of the facility that will provide services for mail order prescriptions and the number of employees that are located at that facility.

C. Customer Service

1. Complete the chart below to provide information on your organization's customer service.

Customer Service Area	Vendor Response
Average hold time in seconds and average abandonment rate for calls in 2015 and 2016	
Hours of operation of customer service unit	
Will there be a dedicated toll-free customer service unit for the Commission's employees and retirees?	
Will there be a dedicated toll-free customer service unit for the Commission Human Resources Department?	
Number of customer service representatives assigned to the Commission service unit	
Average length of service of the customer service representatives	
Customer service employee turnover rate for 2015 and 2016	
Member satisfaction rating in most recent member satisfaction survey	

2. Describe the training process for your customer service representatives.

3. Are any of your customer service functions outsourced? If yes, please list.

4. Does your organization perform client specific customer service satisfaction surveys? If yes, how frequently and what guidelines are followed?

5. Outline the procedure an employee is to follow if a satisfactory resolution is not received from your customer service staff.

6. Who would be the primary individual (Account Executive) responsible for maintaining and updating all group information through the year and working directly with the Commission? Please include name, experience, years with vendor, professional biography, and number and size of other clients they are currently servicing.

7. Who would be the individual (Account Executive backup) that would be available in the absence of the above-named Account Executive? Please include name, experience, years with vendor, professional biography, and number and size of other clients they are currently servicing.

8. Advise on your willingness to attend Commission-sponsored open enrollment meetings or seminars.

9. Do you provide group-level and member-level newsletters or other publications? On what topics? Please provide samples.

10. Indicate your willingness to participate in health benefits fairs at multiple locations in-state, and discuss activities you can present.

11. Do you have a 24-hour phone number that members can call to speak with a pharmacist? To speak with a customer service representative? Can refills be ordered over the phone and online?

12. The Commission applies for the employer drug subsidy for Medicare Part D and will require monthly reports from the prescription vendor for this service. What services do you provide with regard to Medicare D and the employer drug subsidy? Do you have dedicated resources for Medicare processes? If so, please explain. Are there any costs associated with these services? If so, provide all costs associated with Medicare D in your cost submittal.

D. Program Administration

1. Describe in detail your Claims Appeal process including the names of the companies you contract with to conduct the external review.

2. Describe the system edits, procedures, and internal and external audit processes used to ensure that valid claims based on covered medications and plan provisions are paid by the plan.

3. Describe the process for ensuring that this plan and the Commission are in compliance with all applicable laws.

4. Describe any current or pending legal actions in which your organization may be involved.

5. What liability insurance limits do you have for individual protection?

6. Are any of your claims administration functions outsourced? If yes, please list.

7. Are any of your claims administered outside of the United States? Is yes, please provide details.

8. Complete the chart below to provide information on your organization's claims administration.

Claims Administration Area	Vendor's Response
Turnaround time of claim payments to network pharmacies	
Turnaround time of claim payments to out-of-network pharmacies	
Turnaround time of claim payments to employees	
Turnaround time to pay Commission for claims paid in error	
Coding accuracy for 2015 and 2016	
Financial accuracy for 2015 and 2016	

9. Please describe in detail the reports that are available to the Commission. How much customization is available?

10. Are these reports available in real time and online via the internet?

11. Can these reports be customized for the Commission? If there is a charge associated with customization, please include only in the financial section.

12. Are ad hoc reports available to the Commission? If yes, and if there is a charge for these reports, please include only in the financial section.

13. Please confirm your willingness to provide a comprehensive ASO reporting package including individual claims data and enrollment on a monthly basis. Will there be any additional cost associated with data reporting, including any potential reporting for purposes of government programs? If yes, please include only in the financial section.

14. Please describe your billing procedures. Is electronic billing available? Please describe your electronic billing capabilities including invoices, reports, and payments. Is a detailed bill available each month?

15. Under an ASO arrangement, will the vendor provide rating and underwriting support, including but not limited to rating trends, plan design cost relativities, and recommended COBRA and funding rates? Are any additional fees applicable? If yes, please include only in the financial section.

16. Describe how your organization will handle/provide the required reporting for the Summary of Benefits and Coverage requirement. How will your organization handle the Summary of Benefits and Coverage if only Prescription Drug is covered? If there are costs involved, please include cost in the financial section.

17. Describe your compliance with HIPAA. Include in your response details on your organization's policies on privacy, security (including physical safeguards), electronic data interchange requirements, and HiTech.

18. Describe your capabilities as they relate to the Administrative Simplification provisions of HIPAA. Are you capable of processing enrollment and record changes in accordance with HIPAA requirements?

19. As it relates to HIPAA HiTech, has your company had any breaches?

20. Is your organization currently in any discussions to be purchased by another organization, to purchase another organization, or to merge with another organization? If yes, provide details.

21. Pharmacies and 90-day supply of medications.
    a. Do you participate with designated retail pharmacies for member long-term maintenance prescriptions up to a 90-day supply?
    b. Would the cost to the employee be the same as the mail order cost? Please list any variance.
    c. Would the cost to the employer be the same as the mail order cost? Would the retail dispensing fees apply? Please list any variance.

22. Does your plan use a formulary? If so:
    a. Advise if the formulary is open or closed.
    b. Advise if you are willing to create a customized covered classes/formulary for the Commission.
    c. Please enclose a copy of your formulary as well as an internet and telephone resource for inquiries regarding the formulary.
    d. Explain how your formulary list is developed and by whom.
    e. Explain how often your formulary is changed.
    f. Explain if any exceptions are made to the formulary and describe the process.

23. Advise if there will be any major system changes that could affect enrollment or claims in the next 12-24 months, and how you will ensure minimal disruption to the participant and the Commission.

24. Describe your experience with the Systems, Applications and Products in Data Processing (SAP) system and confirm your ability to interface with SAP in a HIPAA compliant format.

25. Describe your organization's prior authorization process including who initiates, time frames, communications to employees, etc. Provide a list of drugs recommended for prior authorization.

26. Describe your organization's Step Therapy Program.

27. Describe your Coverage Authorization, Drug Education, and Drug Utilization Review (DUR) programs.

28. Describe the process that identifies patients, physicians, and pharmacists who are non-compliant with formulary and other clinical programs, and indicate what you do with this information.

29. Describe current programs that integrate prescription and medical claims data and exchange information with medical case managers. List and briefly describe the criteria used to identify patients for case management, and describe how you integrate with the health care vendor case management programs.

30. Indicate what is needed to facilitate the transfer and integration of prescription and medical claims information with the Commission's health care vendors.

31. Describe any disease state management programs, step therapies, or initiatives, and indicate the value or expected value of these services.

32. Describe how specialty drugs are handled and if there are limitations on how an employee may obtain specialty drugs.

33. Explain if coverage is offered for diabetic supplies and how a member would obtain them. Does the standard copay apply?

34. Describe your approach and philosophy to managing prescription drug costs. Be sure to identify where the drugs are dispensed, contracting approach, utilization review procedures, use of formulary, etc.

E. Website Features

1. Describe your electronic capabilities with respect to electronic and/or online enrollment, maintenance of eligibility records, and access to electronic reports.

2. Describe your employee internet capabilities with respect to online directories, access to claims, view/change enrollment data and ability to order and print ID cards, and other services available to members of the Commission.

3. Describe your employer internet capabilities with respect to online directories, access to claims, view/change enrollment data, and ability to order and print ID cards, and other services available to Human Resources personnel of the Commission.

4. List services available to members on your website and provide a screen shot that shows how claim history is displayed.

5. Describe your internet capabilities with respect to online refills, email notifications, drug information, over the counter purchases, and network availability.

6. Are the following features available to employees through the internet?
   - Formulary specific to employer's plan design
   - Formulary search by brand/generic equivalents
   - Alternative drugs/clinical comparison
   - Generic equivalent for branded products
   - Drug's primary labeled purpose
   - Drug savings (cost calculator to compare generic vs. brand drug costs)
   - Drug savings (cost calculator to determine employee savings of generic vs. brand drugs)
   - Information regarding preferential reimbursement for using certain pharmacies
   - Pill splitting options and associated savings
   - Ability to reorder drugs through mail order
   - History of claims costs/utilization

F. Implementation

1. Provide a detailed implementation timeline identifying each task and target date for a January 1, 2018, effective date. Be sure to include plan setup and 834 interfacing.

2. Describe your experience with 834 interfacing.

3. Would you be willing to conduct a site visit and/or claims office visit for designated members of the Commission?

G. References

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

2. Provide three references of former employer groups of similar size and scope. Include how long each was a customer and the approximate number of employees.

H. Sample Documents Requested

a) Identification card
b) Billing statement (detailed and summary)
c) Enrollment application
d) Sample of the reporting package included
e) Most recent annual report
f) Benefit booklets
g) Plan summary sheets

QUESTIONNAIRE FOR VENDORS – PRESCRIPTION DRUG (Financial Response)

This section applies only to the Prescription Drug Program. Only vendors submitting proposals for the Prescription Drug Program should respond to this section.

All cost information must be separate from the technical portion of the proposal.

1. Self-funded (ASO) arrangement - Provide a PCPM administration fee for an effective date of January 1, 2018. Provide a 3-year rate guarantee. In addition, please provide three (3) additional two (2) year terms for a total of nine (9) years).

2. Self-funded (ASO) arrangement - Please provide budget/COBRA rates and details of the budget rate development. Please use the following rate relativities:

   Actives and Pre-65 Retirees

Single	1.00
EE/Spouse	2.10
Parent/Child	1.40
Parent/Children	1.90
Family	2.80
Composite	

   Post-65 Retirees (Please provide separate rates for the Post-65 retirees)

Single	1.00
EE/Spouse	2.10
Parent/Child	1.40
Parent/Children	1.90
Family	2.80
Composite	

3. Under ASO, is an advance deposit, cash advance, or letter of credit required? If so, are there any payment options available that would eliminate this requirement?

4. Is there an administrative expense for processing run-out claims should there be a desire to switch to a fully-insured program or switch to another Pharmacy Benefit Manager?

5. Please detail any administrative expense that is not included as part of the claim administration fee/retention. Examples of expenses include utilization management programs, ad hoc reports, ID cards, and processing of paper claims.

6. Please provide any cost to transition files during implementation. (scripts, prior authorization history, etc.).

7. Please provide any additional fees associated with the prescription drug proposal, such as: dispensing fees, rebate management fees, administrative fees, reporting fees, pharmacy management savings plans, etc.

8. What is the earliest renewal and COBRA rates can be provided and guaranteed?

9. Please detail your prescription drug pricing guarantees for the ingredient cost component. Specifically, provide pricing **guarantees** on an AWP-X% basis for:
    a) Retail Claims – up to a 34-day supply
        1. Generic claims
        2. Brand claims
        3. Specialty claims
    b) Retail claims – greater than a 34-day supply to a 90-day supply
        1. Generic claims
        2. Brand claims
        3. Specialty claims
    c) Mail order claims
        1. Generic claims
        2. Brand claims
        3. Specialty claims

10. Please provide the definition of a generic drug used in evaluating whether the pricing guarantees have been met. It is preferred that the definition of generic include all generics, and not reconcile "single-source" or "limited distribution" generics under the brand guarantee.

11. How do you determine the cost of generic drugs? Do you have a Maximum Allowable Cost Program? Include a copy of your MAC list and associated costs. How many MAC lists do you maintain?

12. Please provide pricing and details relative to any specialty programs. Include a complete list of specialty drugs along with the pricing and dispensing fees of each.

13. Please provide the applicable term of the prescription drug pricing guarantees (1-year, 3-year, etc.). **Guarantees should be provided for 3 years.** If pricing improvements are included in future years, please provide the applicable guarantees in future years.

14. Are the pricing guarantees applicable by category, or would a shortfall in one category be offset by a gain in another category?

15. Please provide rebate guarantees for retail, mail order, and specialty claims. Specify whether the rebates are per claim, per brand claim, or per "rebateable" claim. Note that "100% of the rebates" is not a guarantee--please provide a guarantee so the Commission can assess how your organization's rebates compare to competing proposals.

16. What is the time frame for distribution of rebates? Can these be received quarterly?

17. What other payments are received from drug manufacturers besides rebates? Are these payments passed through to the Commission? Please explain.

18. Describe the reconciliation process that occurs to demonstrate to the Commission that the pricing guarantees have been met. If guarantees have not been met, describe the process to issue the Commission a "true-up" payment to the minimum contractual discount guarantees.

19. Describe any cost-saving opportunities available with limiting the prescription drug network (i.e. enhanced discount guarantees achieved by excluding certain pharmacies).

20. Please describe the Commission's audit rights associated with verifying appropriate pricing/payment to pharmacies as well as meeting discount guarantees. Also, please verify that reporting will be made available in order to independently verify discount guarantees are met.

21. How often will the pricing terms be reviewed and updated?

22. Please confirm that the Commission can terminate their contract at any time of their choosing, provided that all necessary payments are fulfilled. Provide detailed termination provisions.

23. Appendix F contains individual claims data for the current prescription drug program. Please conduct a re-pricing of the claims for the period 1/2016 through 12/2016. The template has been provided and all fields in "blue" must be completed.

24. Performance Guarantees

    Provide performance guarantees tied to plan implementation (1st year only), member satisfaction, reporting/recordkeeping, quality assurance, and account management. Complete the chart below to propose your performance measures and amount of fee at risk. Please indicate how those measures will be calculated and reported to the Commission. If you would propose other measures, please provide details.

	Vendor's Response
Plan Implementation (first year only)	
Performance standard	
Performance guarantees	
Percent of fee at risk	
Member Satisfaction	
Performance standard	
Performance guarantees	
Percent of fee at risk	
Reporting/Recordkeeping	
Performance standard	
Performance guarantees	
Percent of fee at risk	
Quality Assurance	
Performance standard	
Performance guarantees	
Percent of fee at risk	
Account Management	
Performance standard	
Performance guarantees	
Percent of fee at risk	

25. Please provide a formulary disruption report on the drugs provided in Appendix F.

26. Describe your approach and philosophy to managing prescription drug costs. Be sure to identify where the drugs are dispensed, contracting approach, utilization review procedures, use of formulary, etc.

27. List any internet-based discounts on non-covered prescriptions or over-the-counter products you provide.

PART VII

QUESTIONNAIRE FOR VENDORS – Dental (Technical Response)

This section applies only to the Dental Program. Only vendors submitting proposals for the Dental Program should respond to this section.

A. Company Background

1. Years in group benefit plan administration
2. Products offered
3. Area/Markets served (including counties)
4. Number of total groups
5. Number of groups with over 500 lives covered
6. Number of members covered
7. Number of employees
8. Any subsidiaries and/or affiliates
9. Company financial information and ratings
10. Future plans for group benefit plan administration (i.e. where you see your organization going in the next five years; network development, contracting approaches, other changes, etc.)
11. Explain what differentiates you from your competitors

B. Access/Network

1. Is your provider network leased or owned?

2. Please describe your network including number of dentists, oral surgeons, orthodontists, and other specialists in Pennsylvania, the number outside of Pennsylvania, and the percentage of providers that participate.

3. Describe your national network service area. Is your network accessible to members traveling abroad?

4. Explain how a member would access your network while traveling, both in the United States and abroad.

5. Provide a GeoAccess report using the standards defined below and the employee residence zip code data provided on the census.
   - Two general dentists within 8 miles of an employee's zip code.
   - Two oral surgeons within 8 miles of an employee's zip code.
   - Two orthodontists within 8 miles of an employee's zip code.
   - Two other specialists within 8 miles of an employee's zip code.

6. Complete a network disruption analysis using the top 250 dental providers.

7. Describe how you recruit new providers.

8. Advise of your willingness and capability to develop networks in locations where you do not now have acceptable access. Under what conditions would you do so? What would be the time frame?

9. Describe the process that allows the Commission and its employees to recommend providers for addition to the network.

10. Complete the following chart to indicate provider activity in your networks.

Provider Activity	Vendor Response
Number of dentists involuntarily terminated in 2014, 2015, and 2016	
Provider turnover rate for 2014, 2015, & 2016	

11. Please provide an internet and telephone resource for network participation information.

12. For in-network providers, provide details on your provider-negotiated contracts (specify percentage (%) difference between negotiated amounts vs. charges). Provide the basis for your in-network reimbursement levels.

13. Explain in detail how members residing outside of your service area would be covered and how their benefits will be administered.

14. Explain how the employee and employer are notified of provider changes, network changes, and coverage changes.

15. What are the financial arrangements if a provider terminates his or her contract with your organization in the middle of the course of treatment of a patient?

16. How do you assess member satisfaction in your networks? How often do you conduct this assessment? To whom are the results made available? Please provide specifics on how this is tested, with current results.

C. Customer Service

1. Complete the chart below to provide information on your organization's customer service.

Customer Service Area	Vendor Response
Average hold time in seconds and average abandonment rate for calls in 2015 and 2016	
Hours of operation of customer service unit	
Will there be a dedicated toll-free customer service unit for the Commission's employees and retirees?	
Will there be a dedicated toll-free customer service unit for the Commission Human Resources Department?	
Number of customer service representatives assigned to the Commission service unit	
Average length of service of the customer service representatives	
Customer service employee turnover rate for 2015 and 2016	
Member satisfaction rating in most recent member satisfaction survey	

2. Describe the training process for your customer service representatives.

3. Are any of your customer service functions outsourced? If yes, please list.

4. Does your organization perform client specific customer service satisfaction surveys? If yes, how frequently and what guidelines are followed?

5. Outline the procedure an employee is to follow if a satisfactory resolution is not received from your customer service staff.

6. Who would be the primary individual (Account Executive) responsible for maintaining and updating all group information through the year and working directly with the Commission? Please include name, experience, years with vendor, professional biography, and number and size of other clients currently servicing.

7. Who would be the individual (Account Executive backup) that would be available in the absence of the above-named Account Executive? Please include name, experience, years with vendor, professional biography, and number and size of other clients currently servicing.

8. Advise on your willingness to attend Commission-sponsored open enrollment meetings or pre-retirement seminars.

9. Do you provide group level and member-level newsletters or other publications? On what topics? Please provide samples.

10. Indicate your willingness to participate in health benefits fairs at multiple locations in-state, and discuss activities you can present.

D. Program Administration

1. Describe the process for ensuring that this plan and the Commission are in compliance with all applicable laws.

2. Describe any current or pending legal actions in which your organization may be involved.

3. What liability insurance limits do you have for individual protection?

4. Are any of your claims administration functions outsourced? If yes, please list.

5. Are any of your claims administered outside of the United States? Is yes, please provide details.

6. Complete the chart below to provide information on your organization's claims administration.

Claims Administration Area	Vendor's Response
Turnaround time of claim payments to network providers	
Turnaround time of claim payments to out-of-network providers	
Turnaround time of claim payments to employees	
Turnaround time to pay Commission for claims paid in error	
Coding accuracy for 2015 and 2016	
Financial accuracy for 2015 and 2016	

7. Please describe in detail the reports that are available to the Commission. How much customization is available?

8. Are these reports available in real time and online via the internet?

9. Are ad hoc reports available to the Commission? If yes, and if there is a charge for these reports, please include only in the financial section.

10. Please describe your billing procedures. Is electronic billing available? Please describe your electronic billing capabilities including invoices, reports, and payments. Is a detailed bill available each month?

11. Under an ASO arrangement, will the vendor provide rating and underwriting support, including but not limited to rating trends, plan design cost relativities, and recommended COBRA and funding rates? Are any additional fees applicable? If yes, please include only in the financial section.

12. Describe your compliance with HIPAA. Include in your response details on your organization's policies on privacy, security (including physical safeguards), electronic data interchange requirements, and HiTech.

13. Describe your capabilities as they relate to the Administrative Simplification provisions of HIPAA. Are you capable of processing enrollment and record changes in accordance with HIPAA requirements?

14. As it relates to HIPAA HiTech, has your company had any breaches?

15. Is your organization currently in any discussions to be purchased by another organization, to purchase another organization, or to merge with another organization? If yes, provide details.

16. Advise if there will be any major system changes that could affect enrollment or claims in the next 12-24 months, and how you will ensure minimal disruption to the participant and the Commission.

17. Indicate tools or applications available through your organization for the purposes of improving quality and engaging consumers.

18. Describe your experience with the Systems, Applications and Products in Data Processing (SAP) system and confirm your ability to interface with SAP.

19. Describe your preauthorization process, applicable procedures, and dollar thresholds.

20. How are the following services covered under your plan?
    a. Anesthesia
    b. Pediatric dental specialist services
    c. Hospitalization or attending physician due to the member's general health or physical limitations
    d. Removal of impacted teeth; bony or soft tissue
    e. Tooth implants
    f. Extractions for orthodontic purposes
    g. Periodontics, both surgical and non-surgical
    h. Therapeutic periodontal treatment

21. Explain the process used by network providers to verify an employee's/dependent's eligibility for services.

22. Describe the procedure used by employees to submit claims when an out-of-network provider is used.

23. Explain how out-of-network provider charges are determined for employees. Can the Commission select with which method out-of-network providers are paid?

24. Describe your procedures for administering orthodontia claims, including tracking lifetime maximums.

25. Describe your pretreatment (predetermination) review plan.

26. Describe your COB efforts. What are COB savings as a percent of total paid claims in vendors book of business?

27. Describe your internal and external audits and controls. How will this information be made available to the Commission?

28. How do you define and determine medical necessity and excluded coverage? How are determinations made?

29. Are any discounts provided to members for services received from in-network providers that are non-covered services, such as veneers, whitening, and other cosmetic services?

E. Website Features

1. Describe your electronic capabilities with respect to electronic and/or online enrollment, maintenance of eligibility records, and access to electronic reports.

2. Describe your employee internet capabilities with respect to online directories, access to claims, view/change enrollment data, and ability to order and print ID cards, and other services available to members of the Commission.

3. Describe your employer internet capabilities with respect to online directories, access to claims, view/change enrollment data, and ability to order and print ID cards, and other services available to Human Resources personnel of the Commission.

4. List services available to members on your website and provide a screen shot that shows how EOB and claim history are displayed.

F. Implementation

1. Provide a detailed implementation time line identifying each task and target date for a January 1, 2018, effective date. Be sure to include plan setup and 834 interfacing.

2. Describe your experience with 834 interfacing.

3. Would you be willing to conduct a site visit and/or claims office visit for designated members of the Commission?

G. References

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

2. Provide three references of former employer groups of similar size and scope. Include how long each was a customer and the approximate number of employees.

H. Sample Documents Requested

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

QUESTIONNAIRE FOR VENDORS – Dental (Financial Response)

This section applies only to the Dental Program. Only vendors submitting proposals for the Dental Program should respond to this section.

All cost information must be separate from the technical portion of the proposal.

1. Provide a PCPM administration fee for an effective date of January 1, 2018. Provide a 3-year rate guarantee. In addition, please provide three (3) additional two (2) year terms for a total of nine (9) years.

2. Self-funded (ASO) arrangement - Provide a percent of claims administrative fee option for an effective date of January 1, 2018. Provide a 3-year rate guarantee. In addition, please provide three (3) additional two (2) year terms for a total of nine (9) years.

3. Please provide budget rates and details of the budget rate development. Please use the rate relativities listed below:

Actives and Pre-65 Retirees	
Single	1.00
EE/Spouse	2.13
Parent/Child	2.02
Parent/Children	2.24
Family	3.20
Composite	

4. Under an ASO funding arrangement, is an advance deposit, cash advance, or letter of credit required? If so, how is the initial amount determined? How is each subsequent year determined?

5. Are there any payment options available that would eliminate the need for an advance deposit, cash advance, or letter of credit (i.e., weekly billing)?

6. Under an ASO funding arrangement, is there an administrative expense for processing run-out claims should there be a desire to return to a fully-insured program or switch to another self-funded administrator?

7. For in-network providers, please provide details on your provider-negotiated contracts (specify percentage difference between negotiated amounts vs. charges). Provide the basis for your in-network reimbursement levels.

In addition, please provide the average per-service cost for the listed services provided in the following zip codes:

Procedure Code	Description	Zip Code 17111	Zip Code 17601	Zip Code 15537
D0120	Periodic oral evaluation - established patient			
D1110	Prophylaxis - adult			
D0274	Bitewings - four radiographic images			
D0220	Intraoral - periapical first radiographic			

Procedure Code	Description	Zip Code 17111	Zip Code 17601	Zip Code 15537
	image			
D0272	Bitewings - two radiographic images			
D1120	Prophylaxis - child			
D2392	Resin-based composite - two surfaces, posterior			
D0140	Limited oral evaluation - problem focused			
D1208	Topical application of fluoride - excluding varnish			
D2391	Resin-based composite - one surface, posterior			
D1206	Topical application of fluoride varnish			
D4910	Periodontal maintenance			
D8670	Periodic orthodontic treatment visit			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)			
D0150	Comprehensive oral evaluation - new or established patient			
D0330	Panoramic radiographic image			
D9223				
D0210	Intraoral - complete series of radiographic images			
D1351	Sealant - per tooth			
D2330	Resin-based composite - one surface, anterior			
D2740	Crown - porcelain/ceramic substrate			
D2393	Resin-based composite - three surfaces, posterior			
D2331	Resin-based composite - two surfaces, anterior			
D0230	Intraoral - periapical each additional radiographic image			
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth,			
D2950	Core buildup, including any pins			
D2150	Amalgam - two surfaces, primary or permanent			
D2332	Resin-based composite - three surfaces, anterior			
D2140	Amalgam - one surface, primary or permanent			
D7240	Removal of impacted tooth - completely bony			
D2750	Crown - porcelain fused to high noble metal			
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)			
D3330	Endodontic therapy, molar (excluding final restoration)			

8. How often do you negotiate contracts with in-network service providers?

9. Please provide the average dental discounts as of January 2017 for a dentist in the following counties:

	Dentist
Allegheny	
Beaver	
Bedford	
Berks	
Bucks	
Carbon	
Chester	
Cumberland	
Dauphin	
Delaware	
Fayette	
Franklin	
Fulton	
Huntingdon	
Lancaster	
Lackawanna	
Lawrence	
Lebanon	
Lehigh	
Luzerne	
Montgomery	
Perry	
Philadelphia	
Schuylkill	
Somerset	
Westmoreland	

10. Appendix G contains individual claims data for the current dental program. Please conduct a re-pricing of the claims for the period 1/2016 through 12/2016. The template has been provided and all fields in "blue" must be completed.

11. Performance Guarantees—Provide performance guarantees tied to plan implementation (first year only), member satisfaction, reporting/recordkeeping, quality assurance, and account management. Complete the chart below to propose your performance measures and amount of fee at risk. Please be sure to include the following: claims turnaround, accuracy of claim payment, customer service problem resolution, timely issuance and accuracy of identification cards, employee benefit booklets, and program contracts.

	Vendor's Response
Plan implementation (first year only)	
Performance standard	
Performance guarantees	
Percent of fee at risk	
Member Satisfaction	
Performance standard	

Performance guarantees	
Percent of fee at risk	
Reporting/Recordkeeping	
Performance standard	
Performance guarantees	
Percent of fee at risk	
Quality Assurance	
Performance standard	
Performance guarantees	
Percent of fee at risk	
Account Management	
Performance standard	
Performance guarantees	
Percent of fee at risk	

12. Please detail any administrative expense that is not included as part of the claim administration fee/retention. Examples of expenses include ad hoc reports, ID cards, and open enrollment meetings.

13. Please list the percentage of eligible employees that must be enrolled under your group plans. Does that change if more than one vendor for the same line of coverage is awarded a contract?

PART VIII

QUESTIONNAIRE FOR VENDORS – Vision (Technical Response)

This section applies only to the Vision Program. Only vendors submitting proposals for the Vision Program should respond to this section.

A. Company Background

1. Years in group benefit plan administration
2. Products offered
3. Area/Markets served (including counties)
4. Number of total groups
5. Number of groups with over 500 lives covered
6. Number of members covered
7. Number of employees
8. Any Subsidiaries and/or Affiliates
9. Company financial information and ratings
10. Future plans for group benefit plan administration (i.e. where you see your organization going in the next five years; network development, contracting approaches, other changes, etc.)
11. Explain what differentiates you from your competitors

B. Access/Network

1. Is your provider network leased or owned?

2. List the major "chain" providers in your network.

3. Please describe your network including number of optometrists, ophthalmologists, and opticians in Pennsylvania, the number outside of Pennsylvania, and the percentage of each type of provider that participates.

4. Describe your national network service area. Is your network accessible to members traveling abroad?

5. Explain in detail how members residing outside of your service area would be covered and how their benefits will be administered.

6. Provide a GeoAccess report using the standards defined below and the employee residence zip code data provided on the census.
   - Two optometrists within 8 miles of an employee's zip code.
   - Two ophthalmologists within 8 miles of an employee's zip code.
   - Two opticians within 8 miles of an employee's zip code.

7. Complete a network disruption analysis using the top 250 vision providers.

8. Describe how you recruit new providers.

9. Advise of your willingness and capability to develop networks in locations where you do not now have acceptable access. Under what conditions would you do so? What would be the time frame?

10. Describe the process that allows the Commission and its employees to recommend providers for addition to the network.

11. Complete the following chart to indicate provider activity in your networks.

Provider Activity	Vendor Response
Number of vision providers involuntarily terminated in 2014, 2015, and 2016	
Provider turnover rate for 2014, 2015, and 2016	

12. Please provide an internet and telephone resource for network participation information.

13. For in-network providers, provide details on your provider-negotiated contracts (specify percentage (%) difference between negotiated amounts vs. charges). Provide the basis for your in-network reimbursement levels.

14. Explain how a member would access your network while traveling, both in the United States and abroad.

15. Explain how the employee and employer are notified of provider changes, network changes, and coverage changes.

16. What are the financial arrangements if a provider terminates his or her contract with your organization in the middle of the course of treatment of a patient?

17. How do you assess member satisfaction in your networks? How often do you conduct this assessment? To whom are the results made available? Please provide specifics on how this is tested, with current results.

C. Customer Service

1. Complete the chart below to provide information on your organization's customer service.

Customer Service Area	Vendor Response
Average hold time in seconds and average abandonment rate for calls in 2015 and 2016	
Hours of operation of customer service unit	
Will there be a dedicated toll-free customer service unit for the Commission's employees and retirees?	
Will there be a dedicated toll-free customer service unit for the Commission Human Resources Department?	
Number of customer service representatives assigned to the Commission service unit	
Average length of service of the customer service representatives	

Customer service employee turnover rate for 2015 and 2016	
Member satisfaction rating in most recent member satisfaction survey	

2. Describe the training process for your customer service representatives.

3. Are any of your customer service functions outsourced? If yes, please list.

4. Does your organization perform client specific customer service satisfaction surveys? If yes, how frequently and what guidelines are followed?

5. Outline the procedure an employee is to follow if a satisfactory resolution is not received from your customer service staff.

6. Who would be the primary individual (Account Executive) responsible for maintaining and updating all group information through the year and working directly with the Commission? Please include name, experience, years with vendor, professional biography, and number and size of other clients they are currently servicing.

7. Who would be the individual (Account Executive Backup) that would be available in the absence of the above-named Account Executive? Please include name, experience, years with vendor, professional biography, and number and size of other clients they are currently servicing.

8. Advise on your willingness to attend Commission-sponsored open enrollment meetings or seminars.

9. Do you provide group-level and member-level newsletters or other publications? On what topics? Please provide samples.

10. Indicate your willingness to participate in health benefits fairs at multiple locations in-state, and discuss activities you can present.

D. Program Administration

1. Describe the process for ensuring that this plan and the Commission are in compliance with all applicable laws.

2. Describe any current or pending legal actions in which your organization may be involved.

3. What liability insurance limits do you have for individual protection?

4. Are any of your claims administration functions outsourced? If yes, please list.

5. Are any of your claims administered outside of the United States? Is yes, please provide details.

6. Complete the chart below to provide information on your organization's claims administration.

Claims Administration Area	Vendor's Response
Turnaround time of claim payments to network providers	
Turnaround time of claim payments to out-of-network providers	
Turnaround time of claim payments to employees	
Turnaround time to pay Commission for claims paid in error	
Coding accuracy for 2015 and 2016	
Financial accuracy for 2015 and 2016	

7. Please describe in detail the reports that are available to the Commission. How much customization is available?

8. Are these reports available in real time and online via the internet?

9. Are ad hoc reports available to the Commission? If yes, and if there is a charge for these reports, please include only in the financial section.

10. Please describe your billing procedures. Is electronic billing available? Please describe your electronic billing capabilities including invoices, reports, and payments. Is a detailed bill available each month?

11. Under an ASO arrangement, will the vendor provide rating and underwriting support, including but not limited to rating trends, plan design cost relativities, and recommended COBRA and funding rates? Are any additional fees applicable? If yes, please include only in the financial section.

12. Describe your compliance with HIPAA. Include in your response details on your organization's policies on privacy, security (including physical safeguards), electronic data interchange requirements, and HiTech.

13. Describe your capabilities as they relate to the Administrative Simplification provisions of HIPAA. Are you capable of processing enrollment and record changes in accordance with HIPAA requirements?

14. As it relates to HIPAA HiTech, has your company had any breaches?

15. Is your organization currently in any discussions to be purchased by another organization, to purchase another organization, or to merge with another organization? If yes, provide details.

16. Advise if there will be any major system changes that could affect enrollment or claims in the next 12-24 months, and how you will ensure minimal disruption to the participant and the Commission.

17. Indicate tools or applications available through your organization for the purposes of improving quality and engaging consumers.

18. Describe your experience with the Systems, Applications and Products in Data Processing (SAP) system and confirm your ability to interface with SAP.

19. Would the member pay a different cost at a "retail provider" versus an "independent provider"? If yes, please list all providers considered to be a "retail provider" that are located in Pennsylvania.

20. Advise if you are able to provide wholesale allowances to the Commission.

21. Are the allowances listed in your plan retail or wholesale? If the member receives additional services (i.e., two pairs of glasses), does the member pay the retail or wholesale price on the second service/product?

22. Explain if "Lasik" is an option under your plan, and any additional options of treatment that can be offered under the plan. Please define how you can cover these services or what discounts a member can expect for these services.

23. Can you provide different coverage levels for the employee/spouse/dependents on the plan such as 12 months vs 24 months to be eligible for lenses? Example: employee – 12 months, spouse 24-months, etc.

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

25. Explain the process used by network providers to verify an employee's/dependent's eligibility for services.

26. Explain how out-of-network provider charges are determined for employees.

27. Describe the procedure used by employees to submit claims when an out-of-network provider is used.

28. Describe your internal and external audits and controls.

29. How are medically-related disorders integrated with the vision plan?

30. Do you require all providers to have on-site dispensing capability?

31. Describe your relationship with optical laboratories.

32. Do you have quality standards for eyewear and optical laboratories?

33. Describe your pretreatment (predetermination) review plan.

E. Website Features

1. Describe your electronic capabilities with respect to electronic and/or online enrollment, maintenance of eligibility records, and access to electronic reports.

2. Describe your employee internet capabilities with respect to online directories, access to claims, view/change enrollment data, and ability to order and print ID cards, and other services available to members of the Commission.

3. Describe your employer internet capabilities with respect to online directories, access to claims, view/change enrollment data, and ability to order and print ID cards, and other services available to Human Resources personnel of the Commission.

4. List services available to members on your website and provide a screen shot that shows how EOB and claim history are displayed.

F. Implementation

1. Provide a detailed implementation time line identifying each task and target date for a January 1, 2018, effective date. Be sure to include plan setup and 834 interfacing.

2. Describe your experience with 834 interfacing.

3. Would you be willing to conduct a site visit and/or claims office visit for designated members of the Commission?

G. References

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

2. Provide three references of former employer groups of similar size and scope. Include how long each was a customer and the approximate number of employees.

H. Sample Documents Requested

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

QUESTIONNAIRE FOR VENDORS – Vision (Financial Response)

This section applies only to the Vision Program. Only vendors submitting proposals for the Vision Program should respond to this section.

All cost information must be separate from the technical portion of the proposal.

1. Provide a PCPM administration fee for an effective date of January 1, 2018. Provide a 3 year rate guarantee. In addition, please provide three (3) additional two (2) year terms for a total of nine (9) years.

2. Self-funded (ASO) arrangement - Provide a percent of claims administrative fee option for an effective date of January 1, 2018. Provide a 3-year rate guarantee. In addition, please provide three (3) additional two (2) year terms for a total of nine (9) years.

3. Self-funded (ASO) arrangement - Please provide budget rates and details of the budget rate development. Please use the rate relativities listed below:

Single	1.00
EE/Spouse	2.00
Parent/Child	1.60
Parent/Children	2.50
Family	3.00
Composite	

4. Under an ASO funding arrangement, is an advance deposit, cash advance, or letter of credit required? If so, how is the initial amount determined? How is each subsequent year determined?

5. Are there any payment options available that would eliminate the need for an advance deposit, cash advance, or letter of credit (i.e., weekly billing)?

6. Under an ASO funding arrangement, is there an administrative expense for processing run-out claims should there be a desire to return to a fully-insured program or switch to another self-funded administrator?

7. List the earliest a renewal and COBRA rates can be provided and guaranteed.

8. For in-network providers, please provide details on your provider-negotiated contracts (specify percentage difference between negotiated amounts vs. charges). Provide the basis for your in-network reimbursement levels.

In addition, please provide the average per-service cost for the listed services provided in the following zip codes. Do not provide ranges.

Code	Description	Zip Code 17111	Zip Code 17601	Zip Code 15537
S0621	Routine ophthalmological examination including refraction; established patient			
V2799	Vision item or service, miscellaneous			
V2020	Frames, purchases			
V2299	Specialty bifocal (by report)			

Code	Description	Zip Code 17111	Zip Code 17601	Zip Code 15537
V2781	Progressive lens, per lens			
V2750	Anti-reflective coating, per lens			
V2760	Scratch resistant coating, per lens			
V2745	Addition to lens, tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens			
V2199	Not otherwise classified, single vision lens			
V2599	Contact lens, other type			
S0592	Comprehensive contact lens evaluation			
V2784	Lens, polycarbonate or equal, any index, per lens			
V2783	Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens			
V2755	U-v lens, per lens			
S0620	Routine ophthalmological examination including refraction; new patient			
V2744	Tint, photochromatic, per lens			
V2399	Specialty trifocal (by report)			

9. How often do you negotiate contracts with in-network service providers?

10. List any other discounts you can provide or other coverage for items such as non-prescription sunglasses, safety goggles, additional pairs of glasses or contacts or colored contacts, special coatings, tints, laser eye surgery, etc.? Are there discounts available for supplies such as contact lens cleaning fluids?

11. Describe any additional cost savings or discounts that are passed to plan sponsor or members as a result of agreements with PPO network providers. For example, are there limits on extra charges for materials (frames/lenses) and services that are not provided under the plan described above?

12. For standard and designer frames, please answer the following questions:
    a. How are retail prices set?
    b. How are discount prices set?
    c. How often do retail prices change?
    d. How often do discount prices change?

13. For lenses, please answer the following questions:
    a. How are retail prices set?
    b. How are discount prices set?
    c. How often do retail prices change?
    d. How often do discount prices change?

14. How often has your reimbursement formula to providers changed in the past 24 months?

15. Are you willing to guarantee the retail and discount prices for frames and lenses? If so, for what time period? If not, why not? Also, do you propose any other pricing guarantees?

16. On average, based on your book of business, for each item listed below, what did members pay out-of-pocket (the amount above the allowance) during 2015 and 2016?

	Member Portion	
	2015	2016
Eye Examination (including dilation)		
Frames		
Standard frame		
Designer frame		
Standard Eyeglass Lenses		
Single Vision		
Bifocal		
Trifocal		
Lenticular		
Optional Eyeglass Lenses		
Progressive lenses – Standard		
Progressive lenses – Premium		
Polycarbonate lenses		
Blended segment lenses		
Intermediate vision lenses		
Photochromic glass lenses		
Plastic photosensitive lenses		
Hi-index lenses		
Polarized lenses		
Optional Eyeglass Lens Coating/Treatments		
Fashion, sun or gradient tinted plastic lenses		
Ultraviolet Coating		
Antireflective coating		
Anti-scratch coating		
Contact Lenses		
Contact Lens evaluation & fitting		
Standard Daily Wear lenses		
Specialty lenses		
Disposable lenses		
Medically necessary contact lenses		

17. What is the average network provider discount? For example, what is the average discount applied to submitted charges?

18. What percentage of frame claims resulted in no out-of-pocket expenses by the member?

19. Are providers required to carry frames within price ranges? Please explain.

20. Describe fully any additional costs the Commission may incur as a result of later transitioning vision claims administration to another supplier.

21. Performance Guarantees—Provide performance guarantees tied to plan implementation (first year only), member satisfaction, reporting/recordkeeping, quality assurance, and account management. Complete the chart below to propose your performance measures and amount of fee at risk. Please be sure to include the following: claims turnaround, accuracy of claim payment, customer service problem resolution, timely issuance and accuracy of identification cards, employee benefit booklets, and program contracts.

	Vendor's Response
Plan implementation (first year only)	
Performance standard	
Performance guarantees	
Percent of fee at risk	
Member Satisfaction	
Performance standard	
Performance guarantees	
Percent of fee at risk	
Reporting/Recordkeeping	
Performance standard	
Performance guarantees	
Percent of fee at risk	
Quality Assurance	
Performance standard	
Performance guarantees	
Percent of fee at risk	
Account Management	
Performance standard	
Performance guarantees	
Percent of fee at risk	

22. Please detail any administrative expense that is not included as part of the claim administration fee/retention. Examples of expenses include ad hoc reports, ID cards, and open enrollment meetings.

23. Please list the percentage of eligible employees that must be enrolled under your group plans. Does that change if more than one vendor for the same line of coverage is awarded a contract?

24. Provide costs for any other add-on cost management service provided.

25. Provide costs for ad hoc reporting.

Appendix A
Proposer Questions Form

Proposer Questions	Pennsylvania Turnpike Commission (PTC) RFP #: 17-10380-7710 Proposer Name:				
#	Page	Section	Section Description	Proposer Question	Commission Response
1.					
2.					
3.					
4.					

APPENDIX B – PROPOSAL COVER SHEET
Pennsylvania Turnpike Commission
Request for Proposal for
Medical, Prescription Drug, Dental & Vision Benefits

RFP# 17-10380-7710

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.

Before starting any work and until completion and final payment is made for the work, or 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. Contractor shall furnish Certificates of Insurance showing the effective date of coverage as outlined below. No work may be performed until the required evidence of Insurance is provided in accordance with the terms of the contract. Contractor shall be responsible for ensuring that all Subcontractors hired by the Contractor are properly insured. Contractor shall not permit any such Subcontractors to start work until such evidence has been provided to the Contractor.

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, except for Professional Liability Insurance, shall be written on an "occurrence" basis.

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.

   If 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, showing 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.

   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.

Upon completion of the contract, an additional certificate(s) of insurance evidencing coverage shall be provided to the Commission with final application for payment.

f) The Commission, and its Commissioners, officers, employees and agents shall be added as ADDITIONAL INSUREDS on all required liability policies (except Workers' Compensation and Professional Liability) for ongoing operations and completed operations on a primary noncontributory basis.

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 required insurance (except Professional Liability).

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

i) The carrying of insurance described below 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 required by the Commission but 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 its 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

3. **Automobile Liability:**

a) Coverage to include All Owned, Hired and Non-Owned Vehicles (or "Any Auto"). If Contractor does not have any Owned Vehicles, Contractor is 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. **Commercial Umbrella Liability:**

a) Policy(ies) to apply on a Following Form Basis of the following:
(1) Commercial General Liability,
(2) Automobile Liability, and
(3) Employers Liability Coverage.

b) Minimum Limits of Liability

Occurrence Limit:	$4,000,000
Aggregate Limit (where applicable):	$4,000,000

5. **Professional Liability:**

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.

c) If Professional Liability coverage is written on a claims made form the following requirements will apply:

1) The retroactive date must be on or before the start of work under this contract;

2) The Contractor must purchase "tail coverage/an extended reporting period" or maintain coverage for a period of three (3) years after the completion of their work/final payment.

6. **Cyber & Privacy:**

a) Contractor shall maintain coverage for third party liability arising out of breach of privacy, inclusive of confidential and proprietary business information, HIPAA violations and other breaches of personally identifiable information and/or protected health information that may arise from their work with this contract.

b) Minimum Limits of Liability:

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

c) Privacy Breach Notification and Credit Monitoring: $1,000,000 Per Occurrence

APPENDIX D – RFP 17-10380-7710

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.

Addendum No. 1

RFP # 17-10380-7710

Medical, Prescription Drug, Dental and Vision Benefits

Prospective Respondents: You are hereby notified of the following information regarding the referenced RFP:

REVISION

1. **Part IV-3 is revised to read:**
   IV-3. Requirements. Proposer must be able to complete the requirements exactly as specified 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.

QUESTIONS & ANSWERS

Following are the answers to questions submitted in response to the above referenced RFP as of February 27, 2017, all the questions have been listed as received by Conrad Siegel Actuaries.

PROPOSER QUESTIONS – GENERAL QUESTIONS

#	Page	Section	Section Description	Proposer Question	Commission Response
1	3	Part I, I-13	General Information for Proposers	Can bidders restart page numbering within each section?	Yes
2	19	Part IV	Proposal Requirements	Can you let us know which section of the RFP we should include the signed Proposal Requirements in?	This can be included in the Technical Section
3	9	II.10	Cost Submittal	To ensure we a providing an accurate financial proposal for PA Turnpike to consider our financial proposal must include a few standard assumptions around enrolled members, claims, and demographics. Please confirm that standard industry assumptions are permissible.	We are unclear what assumptions would be necessary. Please clearly list any assumptions that are being made.
4	17	B-4	Proposal Requirements	Can the Turnpike Commission please provide clarification/examples as to what you consider "annual accounting reports."	These are the annual performance, claims and administrative fees reports showing actual spend and reconciliation as it pertains to the PTC. Additionally, we need reports on over all unitization relative to our population. These are usually standard reports.
5		Part IV	Work Statement	What are the estimates for the union and non-union PTC workforce over the term of the proposed contract, 1/1/18 through 12/31/2020 with three (3) two-year renewal options?	There is a minimal reduction in workforce anticipated.
6	3,7	Part I	General Information for Proposers	Do we have to complete a separate Appendix (B, C and D) for each line of coverage we are quoting?	No, the proposer need only complete the Appendices once.
7	13	A	General Plan Information	We understand there is a wellness program in place for the PPO plans, can you please confirm what wellness activities are currently being supported?	Listed below is a brief description of the Wellness Program 1) Awareness building 2) Wellness Profile/Health Assessment required 3) Preventive screenings required. Screening includes: o Full Lipid Panel (HDL, LDL, Total Cholesterol & Triglycerides) o Blood pressure o Glucose o Height/Weight 4) Annual physical exam required. Contribution Waiver o If the employee/retiree (under age 65) complete numbers 2, 3 and 4 listed above, the employee/retiree (under age 65) will receive a contribution waiver which will eliminate their contribution for the upcoming year's medical benefits. If the employee/retiree (under age 65) does not complete numbers 2, 3 and 4 listed above, contributions will be effective on October 1, 2018 and thereafter.

#	Page	Section	Section Description	Proposer Question	Commission Response
8	3	I-12	Response	Please consider extending the RFP due date.	There will not be an extension granted for the RFP
9	2	I-6	Contractor Integrity Process	Elaborate on the details of the annual ethics training. Who would need to attend?	Awarded Proposer will determine who should attend. The PTC prefers all who will be working on the contract. The training involves a onetime visit to awarded proposers location (if their office is in Pennsylvania) that discusses ethics, Commission's Code of Conduct and Business Conduct Guidelines. After the initial training awarded proposer will receive a yearly email request to go online and review a power point presentation on ethics.
10	9	II	DB Requirements	Your RFP did not specifically identify an allocation percentage for DB Requirements. What are the expected DB allocations in order to qualify?	See RFP Section II-9 and Appendix D – Diverse Business Requirements Item C – Submission Requirements – Consultant Responsiveness.
11	9	II	Information Required from Proposers	With respect, to ASO administration fees, is the Turnpike requesting Incurred or Paid ASO fees?	Please quote both.
12	9	II-6	Information Required from Proposers	Can you please clarify what information should be provided for subcontractors?	See RFP Section II-6 – Personnel.
13	72	Appendix D (Page 2)	Appendix D	Minimum Participation Level (MPL). The minimum participation level (MPL) for the inclusion of DBs will be established in the RFP/advertisement as a percentage. On page 9 of the RFP it says there is no MPL for this contract. Please confirm if there is an MPL for this contract.	See RFP Section II-9 and Appendix D – Diverse Business Requirements Item C – Submission Requirements – Consultant Responsiveness.
14	5	Part I	General Information For Proposers	I-22 Cost Submittal vs. Part II: Information Required From Proposers Please provide clarification on binder production regarding 3 requested sections (Technical, DBS and Cost). First Possible Scenario: Can we combine Technical and DBS responses into one binder and place the Cost Submittal in a 2nd binder and then place each binder into sealed envelopes? Can both binders (Technical/DBS and Cost) be placed in the same box or does the Cost Submittal have to be shipped separately? (Taken from I-22) Second Possible Scenario: Create 3 separate binders i.e. one for Technical, one for DBS and one for Cost. Place each binder into a sealed envelope. Create 4 copies of each binder for a total of 12 binders. Should each type of binder be shipped separately i.e. all 4 copies of Technical in one box; all 4 copies of DBS in one box and all 4 copies of Cost in one box. (Taken from Part II)	First Possible Scenario is acceptable. Yes, everything can be placed in the same box. Please include 4 copies.
15	12	Part IV	Work Statement	Please confirm where "Part IV-4" is located as referenced within Question IV-3	See Revision #1 above.
16			Medical_Financial Questionnaire	Please provide clarification regarding the Medical Financial Response. 1.Provide PCPM administration fee – please confirm this admin fee is for the active and under age 65 retiree population only 2. Provide % of claims administration fee – please confirm this admin fee is for the over age 65 retiree Medical Supplement population only	We were requesting a PCPM and a % of claims for both the Active, Pre-65 and Post-65 retirees.

PROPOSER QUESTIONS – APPLIES TO ALL BENEFITS

#	Page	Section	Section Description	Proposer Question	Commission Response
1	27, 39, 48, 58	V, VI, VII, VIII	Sample Documents Requested	Can bidders put large samples (such as Provider Directories and Annual Reports on CD-ROM only)?	Yes
2	27, 39, 48, 58	V, VI, VII, VIII	Sample Documents Requested	When you ask for Plan Summary Sheets (in samples) do you mean clarifications and deviations to the current plan designs?	No, we are referring to the Benefit Grids that highlight the benefits
3	27, 38, 48, 58	V, VI, VII, VIII	Implementation	RFP Question 3: Would you be willing to conduct a site visit and/or claims office visit for designated members of the Commission? What is the Turnpike looking for here?	Would employees of the HR/Benefits Department be able to tour the proposer's facility? Such as Customer Service, claims processing unit, etc.
4	27, 38, 48, 58	V, VI, VII, VIII	Implementation	Each section is requesting an implementation timeline. Would you like an overall timeline; or a medical-only timeline, a prescription drug-only timeline, a vision-only timeline and a dental-only timeline?	Please provide a timeline specific to each benefit.
5			General RFP question	RFP Question: "How do you assess member satisfaction in your networks?" Proposer Question: Can the Turnpike Commission please clarify if you are asking about (1) how satisfied members are with the breadth and depth of our network, (2) are you asking about patient satisfaction with their doctor, or (3) are you asking for satisfaction among our actual physicians/hospitals with us?	All 3 of the areas that you mention

PROPOSER QUESTIONS - MEDICAL

#	Page	Section	Section Description	Proposer Question	Commission Response
1	20	V	Section B-3	The attachments include separate census for Highmark and Aetna populations. How would you like the GeoAccess Analysis run? Separate reports – one for HM and one for Aetna? One combined report? Or two separate AND one combined?	Two Separate and One Combined
2	24	V	Section D - 16	Please clarify what the Turnpike Commission means by "required reporting for SBC documents."	SBC = Summary of Benefit Coverages. This is the summary that Insurance companies and health plans must provide annually. Will the proposer provide? What if the Rx is covered under another vendor? How will the proposer handle?
3	28	V	Financial	Can the Turnpike please provide clarification about whether you will be "weekly" billed or "monthly" billed?	Billed Weekly
4	9	Part II - 10	Information Required	Is it the commissions' expectation that they will place all the medical benefits with one carrier?	That would be ideal, but not the expectation.
5	22	V	Customer Service	RFP Question 1: Complete the chart below to provide information on your organization's customer service. And RFP Question 4: Does your organization perform client specific customer service satisfaction surveys? If yes, how frequently and what guidelines are followed. Proposer Question: Can the Turnpike Commission please clarify if you are asking about customer service satisfaction or member satisfaction with the health plan?	Question # 1 is a blend. The first three items in the chart are referring to the member. Question # 4 is referring to the member.
6	31	V	Performance Guarantees	Does the Turnpike Commission want a member satisfaction with customer service PG or an overall member satisfaction (health plan) PG?	Member satisfaction with customer service PG
7			Medicare Advantage Plans	Does the Turnpike wish the plans to be quoted to match current benefits? Can alternative MA plans options be quoted?	Yes, match current benefits. In addition, alternate plans may be offered.
8	25	V	D. Program Administration	Please define what is meant by "High-Value Health Care".	This is referring to Value Based reimbursement programs.
9	25	V	D. Program Administration	Q. #13_ What is meant by "comprehensive ASO reporting package" and "potential reporting for purposes of government programs"?	Comprehensive ASO reporting package would include standard reporting along with Individual Claims Data. Government reporting is referring to the 1094/1095 reporting.
10	14	V	Access/Network	In order to provide the requested Disruption Analysis for the Aetna providers, we need the Provider NPI number. The list of top 500 providers does not include the NPI number. All carriers are required to use the NPI numbers.	We are attempting to obtain this information; however, please proceed with the current information.

PROPOSER QUESTIONS – PRESCRIPTION DRUG

#	Page	Section	Section Description	Proposer Question	Commission Response
1	36	VI	Section D - 16	Please clarify what the Turnpike Commission means by "required reporting for SBC documents."	SBC = Summary of Benefit Coverages. This is the summary that Insurance companies and health plans must provide annually. Will the proposer provide if the proposer is only covering Rx?
2	40	VI	Financial	Can the Turnpike please provide clarification about whether you will be "weekly" billed or "monthly" billed?	Billed Weekly
3	40	VI	Financial	Can the Turnpike Commission please provide clarification about whether the prescription drug program will also be quoted with a percent of claims administrative fee?	No, the Prescription Drug should not be quoted as a % of claims
4		VI	Financial	Is the commission seeking a traditional or transparent arrangement?	Bidders are encouraged to submit the most competitive proposal. There is not a preference.
5		VI	Financial	Are there any chains excluded from the retail network today?	No
6		VI	Financial	Confirm exclusive specialty is currently in place.	Yes - Force to Aetna specialty network after 1st fill
7		VI	Financial	Does the Aetna formulary have any exclusions?	No – the exclusion list does not apply to the Commission plan. However, per the Commission plan bulk chemical compounds and unapproved drugs are excluded
8		VI	Financial	For the Rx plans, it appears there is no difference between the Active and Retiree plans. Please confirm.	The Active and the Pre-65 are the same. The over 65 is slightly different ($ & % - whichever is greater). Please refer to the benefit grids.
9		VI	Financial	Confirm if the Rx plans have any Prior Authorizations, Quantity Limits or Step Therapy programs in place	Per the Commission plan – Prior Authorization applies to acne meds for members over age 25, Actiq and growth hormones
10		VI	Claims File – Provided with RFP	The claims file provided does not include any indicators, which show which claims are attributable the any of the 3 various Rx specific plan designs. It was noted that there are 19 different plan codes included in the file. Please identify which plan codes are attributable to each of the Rx specific plan designs.	On 2/28/2017, an updated claims report was provided to all interested proposers via secure email by Conrad Siegel Actuaries.
11		VI	Claims File – Provided with RFP	The RFP did not provide specific direction on whether or not a claim by claim submission pricing file is required.	Yes, a claim by claim repricing file is required.
12	37	VI	Program Administration	Is the current formulary open or closed?	Open
13				Please provide information on what therapeutic drug categories are covered under the prescription drug benefit.	On 2/28/2017, Aetna's formulary list as sent to all Rx proposals as reference.

PROPOSER QUESTIONS - DENTAL

#	Page	Section	Section Description	Proposer Question	Commission Response
1	49	VII	Financial	Can the Turnpike please provide clarification about whether you will be "weekly" billed or "monthly" billed?	Billed Monthly
2	47	VII	Program Administration	RFP Question 20: How are the following services covered under your plan? (followed by list of services) Proposer Question: Please clarify. Does the Turnpike Commission want to know what the coinsurance is? What the limits are as far as frequency?	Yes, we want to verify that it is a covered service and also how it would be covered (coinsurance and plan limits)
3	49	VII	Financial	The bid requests a five tier structure. Can we obtain a census that provides enrollment by five tiers for the 846 current subscribers? The census attached only provides subscribers, child, and spouse.	On 2/28/2017, an updated census was provided to all interested dental proposers via secure email by Conrad Siegel Actuaries.
4	49	VII	Financial	Are current/renewal (budget) rates available?	No
5	49	VII	Financial	What does "PCPM" mean?	Per Contract Per Month
6	49	VII	Financial	Do the rates for the three (3) two (2) year contract periods need to be a guaranteed rate or is there flexibility with these rates?	Preference is guaranteed, but there is flexibility
7	49	VII	Financial	What is the Out of Network Provider reimbursement? Is it at the current plan's maximum plan allowance or is there a different reimbursement level such as 90th percentile?	OON reimbursement is at MAC allowances of the Advantage network if the provider is in Pennsylvania. For all other states, reimbursement is at the 90th Percentile.
8	49	VII	Financial	Are number of claims available for the experience period provided?	The number of claims can be obtained from the Individual Claims Data
9	51	VII	Financial	Can we get the Provider addresses, Provider Tax ID numbers, and the Dates of Service for each of the claims?	This information will not be provided.

PROPOSER QUESTIONS - VISION

#	Page	Section	Section Description	Proposer Question	Commission Response
1	59	VIII	Financial	Can the Turnpike please provide clarification about whether you will be "weekly" billed or "monthly" billed?	Billed Monthly
2	14	IV.3.A	General Plan Information Section	Would we be able to offer a Fully Insured Vision Quote, with some minor benefit level differences, in place of the Self-Funded Vision Plan requested?	The PTC is not interested in changing the vision to a fully-insured arrangement.
3	59-60	VIII	Financial Response	Please define "average per-service cost." Is this charges? Amount paid by member? Amount paid by the plan/group? Does average per-service cost refer to average retail cost? Please note; vision materials are based on the providers' retail and the allowances which vary significantly.	We are looking for the Maximum Provider Reimbursement Allowance
4	61	VIII	Financial Response	RFP Question 16: On average, based on your book of business, for each item listed below, what did members pay out-of-pocket (the amount above the allowance) during 2015 and 2016? (followed by chart) Proposer Question: Are we expected to provide total dollars based on the defined book of business or a per line item dollar amount? Proposer Question: Optional eyeglass lenses and optional eyeglass lens coating/treatments are not part of the insured vision benefits. Members are offered discounted pricing at in-network providers. Therefore, allowances are not applicable as the member would be responsible for the discounted amount only. That said, what data would the Turnpike Commission like us to provide here? Proposer Question: Please define "book of business," (i.e., commercial group business with 100+ members). Our book of business includes: commercial group with various market segments, individual accounts, CHIP, Medicare Advantage, EHB for pediatric vision.	A per line dollar amount that would be per member. Example would be: Progressive lenses – Premium $90, Hi-index lenses $55, Frames $44, etc. Provide the average cost even if it is based on a discounted amount. Include all employer groups
5	1 of PDF		Premier_Advantage_Vision_Highmark PDF	Standard and Premium Progressive Lenses - Does the out-of-network allowance of $108 include the cost of the bifocal and trifocal lenses?	The OON allowance is the maximum allowed amount. The allowance takes the place of the standard lenses OON allowance for bifocal and trifocal lenses.
6	1 of PDF		Premier_Advantage_Vision_Highmark PDF	Polycarbonate Lenses for dependent children, Single, Bifocal and Trifocal - Do the out-of-network allowances include the cost of the eyeglass lenses?	The OON allowance is the maximum allowed amount. The allowance takes the place of the standard lenses.

All other terms, conditions and requirements of the original RFP dated February 16, 2017 remain unchanged unless modified by this Addendum.