THE CITY OF ROCKWALL, TEXAS

REQUEST FOR PROPOSAL

EMPLOYEE BENEFIT PLANS

JANUARY 1, 2017

RFP#2016-20

Self-insured Medical PPO and Fully Insured Medical PPO
Medical Stop Loss Insurance
Prescription Drug Service
FSA
Fully Insured Dental
Vision Plan
EAP Services
Voluntary LTD and STD

NOTICE TO BIDDERS

Sealed request for proposals will be received by the Purchasing Agent of the City of Rockwall, 385 S. Goliad, Rockwall, TX 75087 until **2:00 pm.**, local time, June 17th and publicly read the names of the respondents in the City Hall Council Chambers at the address noted above for furnishing:

Self-insured Medical PPO and Fully Insured Medical PPO
Medical Stop Loss Insurance
Prescription Drug Service
FSA
Fully Insured Dental
Vision Plan
EAP Services
Voluntary LTD and STD

Proposal forms, specifications and all necessary information may be obtained from Purchasing Agent at The City of Rockwall, 385 S. Goliad, Rockwall, TX 75087. Questions must be in writing to the above address by the deadlines stated within the proposal. **Proposals shall be returned to the Purchasing Agent, at the above stated address and time**.

The City reserves the right to reject any or all proposals, in whole or part, or to accept any proposal or combination of proposals deemed advantageous to it.

Vendors requesting the proposal documents should call Lea Ann Ewing at the City of Rockwall at (972) 771-7700 or by Email: lewing@rockwall.com. Please make reference to Proposal Number **RFP #2016-20**. Closing Date: **June 17th, 2016**

Bid Issue:	May 20, 2016
First Publication:	May 20, 2016
Second Publication:	May 27, 2016
Questions in Writing deadline:	June 9, 2016
Final Response to Vendor Questions:	June 10, 2016
Due Date:	June 17, 2016
Tentative Council Approval:	October 2016

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I. GENERAL INFORMATION

1.0 City of Rockwall

The City of Rockwall is a suburban municipality located east of Dallas, Texas.

The City of Rockwall offers benefits to all full-time employees who are in a position budgeted to work at least 30 hours per week. Coverage begins on the 31st day of continuous employment. All eligible employees are able to choose either the Core, Standard or Premium plans. The City of Rockwall also offers benefits to dependents. An eligible dependent is defined as (1) your legal spouse, (2) your unmarried, dependent children up to age 19, or (3)your unmarried, dependent children up to age 19 through 26 provided they are full-time students at a post-secondary or an accredited college or university. Retirees are not covered or eligible for benefits.

The City has approximately 260 full time employees.

2.0 Requests for Proposals

The City is requesting proposals for a January 1, 2017 effective date.

2.1 The City is requesting proposals for the following:

6.1.1 To duplicate the current plans as well as offer a self-funded medical plan option.

2.2 The City recognizes the fact that there are very important considerations involved other than the rates/charges, **and therefore will not be bound to accept the lowest cost proposal**. Proposals will be judged on the following criteria:

2.2.1 Competitiveness of fees; ability to provide multi-year rate guarantees; and ability to control cost through health management and quality controls.

2.2.2 Ability to underwrite and administer coverages requested in the RFP.

2.2.3 Extent of network coverage and access for the City's employees/dependents.

2.2.4 Ability to deliver a provider network that represents the highest quality care available.

2.2.5 Level of ability to provide administrative services.

2.2.6 Ability to generate meaningful, usable management reports for the City.

2.2.7 Willingness to provide effective benefit communication materials (i.e. summary plan booklets, claims forms, EOBs, etc.).

2.2.8 Willingness to assist with the enrollment meetings at implementation and ongoing annual enrollment periods.

2.2.9 Ability to provide the necessary software to support electronic membership eligibility in compliance with HIPAA requirements.

2.2.10 Ability of the proposer to assume the work in a timely manner.

2.2.11 Financial stability, service reputation, references, and experience with other clients of similar size and/or government entities.

3.0 This proposal addresses the Self-insured Medical PPO and Fully Insured Medical PPO, Medical Stop Loss Insurance, Prescription Drug Service, FSA, Fully Insured Dental, Vision Plan, EAP Services and Voluntary LTD and STD. These plans will expire December 31, 2016. The City will review all proposals and recommend the most advantageous plan meeting the specific criteria detailed herein. Proposers shall indicate any specific restrictions if awarded contracts for less than the current enrollment. The City's goal is to award one administrator a contract for both medical plans and dental plans with an effective date of January 1, 2017, however the City reserves the right to accept or reject any and all proposals.

4.0 For purposes of this bid, provider/administrator refers to a provider of any of the plans specified. Please be advised benefits may be richer but not reduced. Proposals will be reviewed by staff that may then conduct an on-site visit or request a meeting with officials for clarification of the program's benefits.

5.0 The City of Rockwall intends to enter into a multi-year agreement for the provision of its medical and dental insurance plans. The prices quoted for this Agreement shall be for a twelve (12) month period. The extension of this Agreement will be on a year-to-year basis to a maximum of three (3) years if it is determined to be in the best interest of the City and mutual agreement can be reached. The renewal shall be received by the City of Rockwall at least 90 days prior to the expiration of the contract.

6.0 The City believes that the data contained in these specifications is sufficient for the preparation of proposals. The information is believed to be accurate and is based on the latest available information, but is not to be considered in any way as a warranty. Requests for additional information will be considered depending on the proposal time frame and the availability of the requested information. Such information will be submitted to all known proposers simultaneously.

7.0 One original plus two (2) copies plus two CD-RW or two flash drives of the proposal must be submitted to facilitate evaluation. If the copies are not submitted with the original, the bid may be considered as "non-responsive to specifications" and may not be considered for further evaluation. Proposers shall use the format of this RFP in responding.

8.0 The information contained in this request for proposal is confidential and is to be used only in conjunction with preparing this document.

9.0 The City currently recognizes Holmes Murphy and Associates, Inc. as the benefits consultant for all benefit plans and related issues. Therefore, all quotes shall be provided net of commission, consulting and broker fees, and no taxes.

10.0 The City may award a contract on the basis of proposals received, without discussions. Therefore, each proposal should contain the proposer's best terms from a financial and technical standpoint. **Please also indicate any and all contingencies for your proposal**

The City may develop a short list of qualified companies, conduct interviews and select a healthcare provider/administrator to provide the health and dental plans requested.

At the conclusion of presentations, and on the basis of the evaluation factors as stated in the RFP and information developed in the selection process, the City shall rank in order of preference the professional qualifications and proposed services that are deemed most meritorious. The City may negotiate with one or more proposers and no proposers shall have any rights against the City arising from such negotiations or any invitation to negotiate.

Negotiations shall then be conducted for a contract to provide health care services beginning with the proposer ranked first. If a contract satisfactory and advantageous to the City can be negotiated at a price fair and reasonable, the award shall be made to that proposer.

Otherwise, negotiations with the proposer ranked first shall be formally terminated and negotiations conducted with the proposer ranked second, and so on until such a contract can be negotiated at a fair and reasonable price.

11.0 All proposals should assume a January 1, 2017 implementation date and all Proposers must agree that their proposals are valid until January 1, 2017.

12.0 The City has sole discretion to cancel this RFP, to reject any or all proposals or any part thereof received prior to contract award, or to waive any formalities.

13.0 The City may request clarification of any proposal after all proposals have been received.

14.0 This RFP does not commit the City of Rockwall to award a contract or to pay any cost incurred in the preparation of a proposal in response to this request.

15.0 Provider/administrators must assume existing COBRA and FMLA participants.

26.0 The City does not guarantee a minimum participation in the plan. Employees may transfer between plans during annual enrollment with an effective date of January 1st with no pre-existing condition clause.

17.0 ACI currently provides administrative services for the following medical plans: Core, Blue and Gold and the self-insured dental. The PPO medical administrative fees include claims administration, claims repricing, precertification, utilization review, subrogation, and large case management. Dental administrative fees include claims administration.

18.0 Funds for payment are provided by the City of Rockwall budget approved by City Council for this fiscal year only. The State of Texas statutes prohibit the obligation and expenditure of public funds beyond the fiscal year for which a budget has been approved. Obligations beyond the end of the current City of Rockwall fiscal year will be subject to budget approval.

19.0 Proposers are expected to comply with all local, state and federal insurance laws and regulations relative to the preparation and submission of proposals. All proposals submitted will be presumed to be in compliance with applicable laws.

20.0 Payment of claims for self-funded plans must be through the City's named depository. The City is prohibited from using out of state depositories.

21.0 No person has authority to verbally alter these specifications. Any changes to specifications will be made in writing and sent to each person having a proposal packet.

22.0 All requests for information, must be in written form, and will be directed to the name and email address below by the stated deadlines herein:

Brittany Wall
Account Manager
Holmes Murphy
bwall@holmesmurphy.com

Each proposer is responsible for taking necessary steps to ensure their proposal is received by the date and time noted herein. The City is not responsible for any mail delays, internal or external, that may result in the proposal arriving after the set time. Proposals received late will not be opened and will not be considered in the proposal process.

II. SPECIFIC REQUIREMENTS

Proposers must comply with the following requirements. Describe how the proposer will comply with each of the following specific requirements. If you are unable to meet a condition please give an explanation.

1.0 All proposals must be prepared and submitted as outlined in this request. The excel document must be fully completed. Supporting documents may be included, however will not be accepted as a replacement of the excel spreadsheet. Failure to complete the document in the format provided may result in disqualification.

2.0 The selected provider/administrator must provide a plan design, which retains the same level of benefits as the current summary plans. Benefits, which exceed the current level, will be acceptable as long as there is a no gain/no loss provision.

3.0 **No commissions, overrides, and/or finder's fees shall be paid to any party. All rates should be quoted net. If fees cannot be quoted net, please explain.**

4.0 No loss/No gain: No covered employee or covered dependent shall lose or gain benefits as a result of a vendor change. All pre-existing condition limitations, actively-at-work and nonconfinement provisions must be expressly waived for the initial enrollment for covered employees and covered dependents that have already satisfied the limitations under the current plan. **Also, any partial or full satisfaction of a current limitation, deductible, or annual co-payment must be credited.**

6.0 Renewal rate computations must be furnished at least 90 days prior to the end of the contract year.

7.0 Multiple year rate guarantees are requested.

8.0 The vendor must agree to attend monthly update and quarterly review meetings at the City's desired location in Rockwall, Texas.

9.0 The vendor must provide a single point-of-contact account manager and local contact medical and dental representative. This person shall be available through a toll-free telephone number and a direct telephone number.

10.0 The vendor that is awarded a contract must agree to transmit test data to a new vendor no less than 30 days prior to the termination of a contract and to provide a final verified transition data file to the new vendor within 30 days after the termination date.

11.0 The vendor that is awarded a contract providing administrative services must provide the City with City- specific comprehensive experience reports monthly and summary reports annually.

12.0 The vendor that is awarded a contract must mail I.D. cards to participant's (employee, COBRA) home address within ten (10) working days after receiving the initial enrollment eligibility file and at the beginning of each plan year. Thereafter, new I.D. cards must be provided to a participant within five (5) working days of receiving any change request.

13.0 The vendor that is awarded a contract must capture employee and dependent information from enrollment materials and maintain it throughout the term of the contract. The City requires access to an automated computer-based system, either on-line or through a PC based package to allow for easy updating of the eligibility data. Eligibility software must be HIPAA compliant. The cost for this service should be included as part of the rate and should provide the following capabilities:

- In-house maintenance of participants' eligibility/census;
- Ability to run standard eligibility/census reports and
- Automatic update or electronic transfer of eligibility data to the vendor provider/ administrator.

14.0 Properly staffed and supervised customer/member service representatives must be available to plan participants via a 1-800 number.

15.0 The vendor that is awarded a contract shall provide and maintain networks of qualified providers that provide quality services on a cost-effective basis for the PPO plans during the term of the contract. Each proposer must ensure that the providers continue to meet licensing, selection, and screening criteria and that required liability insurance is maintained. Each proposer must confirm in its response that its proposed network will remain under agreement throughout this proposal process. Subsequent to submission, any material changes must be brought to the City's attention immediately. Failure to do so may eliminate the proposal from consideration.

16.0 The City requires that for each type of plan administered the benefits must be interpreted and claims processed in accordance with the summary plan description. The benefits structure of the provider/administrator must be capable of handling this provision.

17.0 All specific reinsurance rates quoted should be based on employee only and employee & family. Aggregate rates and administrative fees should be on a composite basis. The City shall remit payment based on the monthly enrollment invoiced in accordance with this rate structure.

18.0 The vendor awarded a contract will develop and provide a summary handout/overview of plan benefits for initial annual enrollment, employee orientation and ongoing annual enrollment.

19.0 The vendor awarded a contract will provide a supply of enrollment forms and SPD booklets, marketing materials and directories for distribution from the City, as needed.

20.0 If necessary, the vendor awarded a contract must develop and mail a summary of plan changes/amendments to all members at their home address.

21.0 The selected vendor shall provide an actuarial determination of COBRA rates/premiums to the City on an annual basis, the cost to be included as part of the administration rate.

22.0 Services associated with mental health/substance abuse should provide, at a minimum, the following:

- Initial benefit coordination with the City's EAP;
- 24-hour emergency screening;
- Marketing materials explaining benefits offered, methods of access and confidentiality;
- A directory of psychiatrists, licensed counselors, psychologists, professional staff and their credentials; and
- Training programs offered. Attach a copy of the brochure, which outlines the benefits provided.

23.0 All services offered/provided must be clearly identified/explained. All costs must be fully detailed and summarized with exceptions or deviations to specific requirements clearly enumerated.

24.0 All questions including the enclosed questionnaire must be completed in its entirety and submitted with the proposal. Questions not answered in their entirety may disqualify the proposal.

25.0 The City would like access for all eligible employees, COBRA participants and eligible dependents.

26.0 The selected provider/administrator shall notify service providers of the effective date of the contract award of City business and provide the billing address for claim submission relating to City employees/COBRA participants for services rendered after the effective date of this change. This will ensure a smooth transition for claims processing and payments.

27.0 A specimen contract, summary plan description, network directories showing open access to Texas providers, and sample eligibility/cost reports shall be included in the proposal.

28.0 The "actively at work" requirement shall be waived for employees (and dependents) not Performing normal work activities on the effective date. The selected provider/administrator shall include a no-loss, no-gain provision. No person will lose coverage due to a change in provider or administrator.

29.0 The identification cards (ID) and directories, etc. for the initial enrollment must be received by each participant by the effective date of the contract (January 1, 2017). The summary plan document (SPD) must be developed and submitted to each participant not later than March 1, 2017 unless the City has agreed upon another date.

III. SERVICE/PERFORMANCE STANDARDS - GUARANTEES

1.0 For the standards listed below please indicate whether or not you will agree to the performance standards, and the percent of premium you are willing to put at risk. The proposer will be expected to conduct regular internal audits and report the results to the City for use in enforcing performance guarantees. If you are not willing to meet the proposed standard, please explain and propose an alternative performance measure.

2.0 Member ID Card must be processed and mailed to participant within ten (10) working days of member's data being entered by City staff.

3.0 90% of all City enrollees' calls routed to the selected provider/administrator's automatic call distribution system unit shall be answered within an average of 45 seconds during normal business hours.

4.0 95% of all enrollees/providers' appeals shall be resolved within 60 days of receipt.

5.0 At a minimum, the City requires the following claims service guarantees:

a. All enrollees' clean claims will be paid maximum of 14 calendar days from receipt date.
b. 93% of all claims will be correctly coded.
c. 93% of all claims will be correctly and accurately processed.
d. 95% of all claims will be paid accurately.
e. 95% of all claims will be accurately coordinated with other plans.
f. 99% of all claims will be financially drafted correctly.
g. 95% of all City enrollee's claims submitted by the provider/administrator to the insurer shall be paid within 21 days of receipt.

6.0 Selected administrator shall provide a quarterly report indicating their compliance with their published performance standards. Proposers shall provide monetary remedies for failure to meet their performance standards. Describe how you will monitor your performance of these standards.

7.0 The proposer must guarantee that accurate management reports be delivered no later than the agreed upon due date.

8.0 The proposer must guarantee at a minimum, that enrollment data provided by the City will be loaded into the proposer's enrollment system within 48 hours of receipt, an eligibility discrepancy report must be provided to the City within seven (7) working days following receipt of enrollment data.

9.0 The vendor that is awarded a contract shall agree to indemnify and hold harmless the City of Rockwall and its officers, agents, and employees from any and all claims, causes, or actions, and damages of every kind, for injury to or death of any person and damages to property

arising out of or in connection with the work done by Contractor under this contract, and including acts or omissions of the City of Rockwall or its officers, agents, nor employees in connection with said contract.

10.0 All proposals shall include certificates of coverage for fiduciary liability, errors and omissions and fidelity bond including carriers, policy numbers, expiration dates and limits. A certificate of insurance, or a copy of the insurance policy will be furnished to the City within ten (10) days after award of proposal and will provide that the City will receive ten (10) days prior written notice before any change or cancellation of any policy. The City of Rockwall must be named as additional insured on all policies.

11.0 Following is a list of reports required as part of the selected provider/administrator's responsibility. Data is required separately for each type of plan administered. Each report should provide a summary with a total for each category and each employee/dependent group. All reports must be received by the fifth of each month. Cost of these reports must be included in the rate bid.

11.1 Must provide on a monthly basis a hard copy of the employee eligibility/census report by group. A separate census will be required for each type of plan administered. When requested, eligibility report must be provided on diskette. These reports must include the following information:

- employee and dependent names – last, first and middle
- employee SS# and gender
- employee and dependent date of birth
- employee address, including city, state and zip code
- effective date of coverage
- termination date
- medical plan coverage status – E0, E1, E2, E3, E4, etc. with totals for each group
- Suspense report

11.2 Dollar (separate report) amount of claims paid by group and summary of all groups will be required for each type of plan administered. (monthly/quarterly)

11.3 Paid claims register (separate report) per employee and dependents for each type of plan administered. (monthly and quarterly)

11.4 Separate substantial users report by employee/retiree/dependent group (claims of $10,000 and above) by budget year and contract year will be required for each type of plan administered. (monthly/quarterly)

11.5 Separate COBRA participants listing with effective date, level of coverage (employee only, employee +spouse, employee + child(ren) or employee + family coverage), by employee group, premium amount billed and paid, coverage type (i.e., medical/dental/prescription drug), termination date, and paid through date for each type of plan administered. (monthly)

11.6 Large case management activity. (monthly)

12.0 Stop loss carrier must waive any and all actively at work provisions.

IV. SUBMISSION REQUIREMENTS

1.0 Submission Requirements

The City of Rockwall will consider all applicable factors in determining which proposal serves the interests of the City of Rockwall. The City of Rockwall reserves the right to reject any, all, or part of the proposals, and to accept any advantage considered beneficial to the City of Rockwall. The City of Rockwall reserves the right to waive any information or minor technicalities or to accept any proposal deemed advantageous to it.
At all times during the term of this contract, the contractor shall procure, pay for and maintain, with approved insurance carriers, the minimum insurance requirements set forth below, and shall require all subcontractors and sub-subcontractors performing work for which the same liabilities may apply under this contract to do likewise. The contractor may cause the insurance to be effected in whole or in part by the subcontractors of sub-subcontractors under their contracts.

- Workers Compensation: Statutory limits and employer's liability of not less than $100,000 for each accident.

- Commercial General Liability:

  - Minimum Required Limits

    - $1,000,000 per occurrence
    - $1,000,000 General Aggregate

  - Commercial General Liability policy shall include:

    - Coverage A: Bodily injury and property damage
    - Coverage B: Personal and Advertising Injury liability
    - Coverage C: Medical Payments
    - Products – Completed Operations
    - Fire Legal Liability

  - Policy coverage must be on an "occurrence" basis using CGL forms: as approved by the Texas State Board of Insurance.

  - Attachment of Endorsement CG 20 10 – additional insured

  - All other endorsements shall require prior approval by the Contract Administrator or Risk Manager.

- Professional Liability/Errors and Omissions: Employee benefits liability. Minimum required limit: $1,000,000 per occurrence.

- Fidelity Bond: The City of Rockwall requires a fidelity bond in the amount of $1,000,000 for this contract, which shall remain in effect for the term of this contract as modified and extended. The City shall be named as "Loss Payee."

Vendor Name	

Primary Contact Information

Name	
Title	
Address	
Phone #	
Fax #	
Email	

Secondary Contact Information

Name	
Title	
Address	
Phone #	
Fax #	
Email	

Coverages to be Quoted **(Please mark an "x" to all plan types that apply.)**

Medical	
PBM	

PROPOSAL INSTRUCTIONS

RFP Name/No.	
Proposal Closing/Opening Time:	
Proposal Opening Location:	

The RFP and timeline should be reviewed in its entirety. Any questions should be submitted within the deadline; a Q&A Addendum will be released to all carriers interested in submitting a proposal.

Proposals should be completed in the format provided within this file. Proposals not completed in this format may be disqualified for non-compliance.

When completing the questionnaires, answers should be summarized in short format and not exceed the allotted space within the cell(s) provided. **DO NOT** add extra rows/columns--work within the allotted space. Additional information in carrier format may be submitted if a carrier would like to include more detailed information.

EXHIBIT REVIEW SIGN-OFF

I acknowledge that I have reviewed the RFP in its entirety, including the Client Specifications, Current Contract and Client Exhibits. I have also reviewed the RFP timeline within the Client Specifications, which includes important dates that are relevant to this RFP.

I acknowledge I have reviewed and included all Addendums, if applicable, in my proposal.

Failure to submit my proposal in the manner the RFP states and within the indicated date and time will result in disqualification of my proposal.

Signature:	
Print Name and Title:	
Date:	

GENERAL QUESTIONNAIRE		
The following questionnaire must be completed.		
Answers should be summarized in short format. DO NOT add extra rows/columns--work within the allotted space. Additional information in carrier format may be submitted as attachments if you would like to include more detailed information.		
	Organizational Strength	**Response**
1	Provide the name and address of your company.	
2	Is your company publicly traded?	Please Select
3	What is your company's A.M. Best rating?	
	References	**Response**
4	Please provide three references of current clients and two references of clients you have lost in the past two years. Ideally, these references would be similar in size to the Client. All fields must be completed.	**Current Clients**
		1.) Client Name:
		Contact Name:
		Contact Title:
		Phone Number:
		Email Address:
		Years of Service:
		2.) Client Name:
		Contact Name:
		Contact Title:
		Phone Number:
		Email Address:
		Years of Service:
		3.) Client Name:
		Contact Name:
		Contact Title:
		Phone Number:
		Email Address:
		Years of Service:
		Former Clients
		1.) Client Name:
		Contact Name:
		Contact Title:
		Phone Number:
		Email Address:
		Reason for leaving:
		2.) Client Name:
		Contact Name:
		Contact Title:
		Phone Number:
		Email Address:
		Reason for leaving:

MEDICAL QUESTIONNAIRE		
Carrier Name		**ABC Company**
The following questionnaire must be completed.		
Medical health carriers are required to respond to all requests for information contained in this questionnaire. This questionnaire will be scored; therefore, it is necessary that you provide concise answers. Your responses to the questions should be based on your current proven capabilities. Should there be instances where certain questions are not applicable to your organization or its operations, please indicate this. If you are selected to administer the Client's employee benefit plans, your responses to the questionnaire will be considered part of your contractual responsibilities. You are also requested to return the indicated exhibits as part of your proposal.		
Answers should be summarized in short format and not exceed the allotted space within the cell(s) provided. DO NOT add extra rows/columns--work within the allotted space. Additional information in carrier format may be submitted along with the "Attachments" spreadsheet if a carrier would like to include "more detailed" information.		
1	The Client requires Medical, Dental, FSA, Cobra and EAP to be administered by a singular provider. Please confirm all products will be provided and administered under a singular carrier.	Please Select
2	Do you have the ability to administer a Personal Care Account (PCA) as part of the medical plan? NOTE - The PCA account is funded by the employer and works like an HRA to reimburse members for their deductible expense. At the end of the year, any remaining PCA dollars are distributed to the employees in the form of a paycheck.	Please Select
3	Do you have the ability to receive RX claims from third party vendors and integrate for out of pocket maximums?	Please Select
4	Do you have the ability to transfer medical, Rx and eligibility claims data to 3rd party vendors on a monthly basis?	Please Select
5	Are you able to administer direct contracts?	Please Select
Additional Vendor Questions		
Organizational Strength		**Response**
6	How many clients do you currently have inforce in the state of Texas?	Please Select
7	Do you have a specialized team that works with public entity employers?	Please Select
8	How many clients do you currently have in Texas that are public entities?	
Administrative Flexibility		**Response**
9	The Client will require employees to get a preventive care visit. Can you track which employees have received their visits and report this information back to a 3rd party vendor?	Please Select
10	If there is an additional cost, please indicate what that cost will be and make sure it is included in your PEPM administrative fee.	
11	How does your claims system process a preventive care claim?	

MEDICAL QUESTIONNAIRE		
Carrier Name		**ABC Company**
The following questionnaire must be completed.		
12	Are you able to pay a preventive care claim at 100% if a preventive diagnosis is not the primary diagnosis?	Please Select
13	Will you partner with pricing transparency vendors?	Please Select
14	Do you have your own proprietary pricing transparency service?	Please Select
15	Are you able to administer direct contracts for the Client?	Please Select
16	If there is an additional cost for administering a direct contract, please indicate what that cost will be.	
17	Can your system allow for different plan designs or copays to promote steerage to preferred facilities and physicians?	Please Select
18	If so, what is the lead time to make these changes?	
19	If there is an additional cost, please indicate what that cost will be and make sure it is included in your PEPM administrative fee.	
20	Will there be a dedicated banking representative?	Please Select
21	Do you require medical imprest balance?	Please Select
22	If yes, how many days of funding are required to be placed in an imprest account?	
23	What would be the required banking deposit?	
24	What are the banking payment options available? (i.e.: ACH or Wire)	
25	If the imprest account cash balance exceeds $250,000, what type of collateral would be pledged for the account?	
26	If required, where would the collateral be held?	
27	If required, would the collateral be in the Client's name?	
28	What are your preferred/required banks?	
29	What are your banking requirements?	
30	Provide a copy of the sample banking reports	Please Select
31	Can banking reports be made available daily?	Please Select
32	Will you notify the Client prior to a high dollar claim being paid?	Please Select
33	If so, what is the high dollar threshold?	
Implementation Process		**Response**
34	Will you have an onsite representative available for annual open enrollment meetings as requested by the Client?	Please Select
35	Please confirm that a Pre-implementation audit will be performed.	Please Select
36	Can you produce and distribute Client exchange notifications?	Please Select
37	Provide a timeline for implementation.	Please Select
38	Confirm that you will produce the SPD for the Client.	Please Select
39	Confirm the Client will have a dedicated implementation manager.	Please Select
40	Do you have implementation guarantees?	Please Select
41	Confirm that you will produce the SBC for the Client.	Please Select

MEDICAL QUESTIONNAIRE		
Carrier Name		**ABC Company**
The following questionnaire must be completed.		
	Claims Administration	**Response**
42	Please attach a sample of your Administrative Services Agreement.	Please Select
43	Will there be a dedicated claims analyst?	Please Select
44	If so, what experience will be required before they are assigned to the Client?	
45	Additionally, what training will they receive?	
46	What dollar threshold is set for the claims analyst?	
47	Are large claims reviewed by a supervisor?	Please Select
48	What is the threshold for an audit or review?	
49	Will the Client have access to see claims online?	Please Select
50	What is your error/reprocessing rate?	
51	What are the claims processing timeliness measurements?	
52	What are the YTD claims timeliness results?	
53	How will your systems integrate with a PBM vendor in order to comply with the max out of pocket benefit to comply with HCR.	
54	Are you making enhancements to the claim system as part of HCR requirements?	Please Select
55	Please confirm the following systems are integrated: Enrollment, Medical claims processing/ Care Coordination Referral and Authorization/ Contracts.	Please Select
56	What is the percentage of auto adjudication for your claims?	
57	Do you have recommended benefit changes to SPD to increase auto adjudication? (If yes, add to the Deviations-Variations tab)	Please Select
58	What types of claims are auto adjudicated?	
59	Is this based upon a threshold?	Please Select
60	If yes, what is that threshold?	
61	Is there a process in place to verify that these claims have been paid in accordance with the Plan?	Please Select
	Claims Audits	**Response**
62	How many times a year can the Client do a claims audit?	
63	Describe your internal audit claim procedures.	
64	What are the YTD quality audit results?	
65	Please explain large dollar claim auditing criteria.	
	Utilization Management	**Response**
66	How are UM cases identified?	
67	Are any UM activities that your company performs subcontracted?	Please Select
68	If so, who is your subcontractor and how long has that partnership been in place?	
69	If so, are there costs involved with the subcontracting?	Please Select
70	Describe the denial and appeals process for Utilization Management	
71	What is the associated turn-around time for these processes?	
72	Do you have onsite nurses at each hospital indicated on the disruption tab?	Please Select

MEDICAL QUESTIONNAIRE		
Carrier Name		**ABC Company**
The following questionnaire must be completed.		
	Disease Management	**Response**
73	Which disease management (DM) programs do you offer as part of your base fee?	
74	Can the Client carve out these programs?	Please Select
75	How do you integrate your DM programs with PBM programs?	
76	Which disease management (DM) programs do you offer at an additional cost? (Please outline the additional costs on the Fee Tab of the spreadsheet.)	
	Reporting	**Response**
77	Provide a sample of all financial reporting the Client can expect to receive on a regular basis. Additionally, include any Adhoc reports that other clients have found useful in claims analysis.	Please Select
78	Provide 2 SPECIFIC examples of deep dive analysis and recommendations you have provided to other clients within the past 2 years.	
79	Can claims be reported by type (i.e., Retiree, COBRA, employee, medical, dental, etc.)?	Please Select
80	If yes, how are these identified on the reporting file?	
81	Can you break out claims by dependent (i.e., child or spouse)?	Please Select
82	Is the reporting in a format that can be manipulated (ie. Excel, CSV)?	Please Select
83	Can reporting be provided that will have fiscal YTD (10/1 -9/30) and calendar YTD (1/1 – 12/31) that will have claims in detail by type (i.e., COBRA dental, retiree medical, etc.)	Please Select
84	Will you prepare a monthly reconciliation between incurred to paid claims?	Please Select
85	Can you provide a detailed report of large claims and diagnoses?	Please Select
86	Describe the process to communicate with plan administrators information that aids in making timely decisions and/or adjustments.	
87	If you have system updates, please confirm that you will inform the Client prior to system updates occurring and what these updates will effect.	Please Select
88	Provide a sample of your annual health plan review.	Please Select
89	Would the Client have a dedicated reporting analyst?	Please Select
90	What is the standard distribution frequency for each report provided?	Please Select
91	When are you monthly financial reports produced?	
92	Will you set up a schedule to automatically email the standard reports to the Client on a monthly, quarterly and annual basis as requested at no additional cost?	Please Select
93	Will you provide Third Party claims appeal options as required by healthcare reform?	Please Select
94	What is the process for requesting ad hoc reports?	
95	Is there a fee involved?	Please Select
96	If so, what is the fee?	
97	What is the standard turn around time?	
98	Describe how current reporting data is used for predictive modeling and risk management analysis.	
99	Will you send Holmes Murphy a full medical and eligibility claims file monthly?	Please Select
100	If so, outline these costs and make sure this is included in your PEPM administrative fee.	

MEDICAL QUESTIONNAIRE		
Carrier Name		**ABC Company**
The following questionnaire must be completed.		
101	How are you helping your clients with increasing claim cost?	
102	Can you accept 3rd party Rx feeds from ANY PBM and integrate that data into the maximum out of pocket?	Please Select
103	How are you keeping clients informed about HRC requirements and changes?	
104	How will you assist the Client with the 6066 and 6055 reporting?	
	Wellness	**Response**
105	Do you use detailed claim information to help clients design an impactful wellness program?	Please Select
106	If so, provide examples.	
107	Provide examples of recommendations of wellness programs that you have worked with clients on in the past 2 years.	
108	Provide examples of ROI on client wellness activities.	
109	Do you provide an online health risk assessment for members?	Please Select
110	If yes, is this included as part of your base fee?	Please Select
111	Can you provide the Client a full time wellness resource that will be located onsite at the Client?	Please Select
112	If yes, is this included as part of your PEPM fee? If not, outline separately on the pricing spreadsheet.	Please Select
113	Will you include a wellness budget for the Client?	Please Select
114	If yes, is this included as part of your base fee? If not, outline separately on the pricing spreadsheet.	Please Select
115	Describe the wellness programs offered to the Client at no additional charge.	
116	Do you design programs around the conditions of the employee population?	Please Select
117	Do you subcontract any wellness services to an outside vendor?	Please Select
118	If yes, identify which services are outsourced and the name of the subcontractor.	
119	Is e-mail coaching available?	Please Select
120	Does your organization offer discounts to support healthy lifestyles such as gym memberships, vitamins, massage therapy, etc.?	Please Select
121	If yes, is there an additional cost for this program?	Please Select

MEDICAL QUESTIONNAIRE		
Carrier Name		**ABC Company**
The following questionnaire must be completed.		
	Employer/Employee Websites	**Response**
122	Provide a URL, userID and password for the RFP evaluation team to view your **employer** website.	
123	URL	
124	User ID	
125	Password	
126	Provide a URL, userID and password for the RFP evaluation team to view your **member** website.	
127	URL	
128	User ID	
129	Password	
130	Please confirm an in depth, live demo of both employer and employee websites will be given upon request.	Please Select
	Fees and Subrogation	**Response**
131	Do you have any capitated fees?	Please Select
132	Confirm that ASO costs are mature.	Please Select
133	What will be the cost to accept data feeds from 3rd party PBM? (please make sure this amount is included in your PEPM admin. fee)	
134	Confirm that you will be able to provide claims subrogation services for the Client. The Client currently uses a Pay and Pursue model.	Please Select
135	Confirm that you can provide monthly reporting to the Client outlining the Subrogation activity/savings.	Please Select
136	Will this service be outsourced to a 3rd party?	Please Select
137	If yes, is there an additional cost for this service?	Please Select
138	If there is an additional cost, please indicate what those costs will be.	
	Customer Service	**Response**
139	Is your call center located within the United States?	Please Select
140	Will there be a dedicated call center to the Client?	Please Select
141	If so, where is this located?	
142	Are there bilingual resources available on this team?	Please Select
143	What are the hours of operation?	
144	What is the turnover percentage of your call center?	
145	What is the turnover percentage of your account management team?	
146	What is the average tenure of the account managers that service the municipalities in your organization?	
147	How many clients do they currently service?	
148	What is the average answer speed?	
149	What are the YTD results for your average speed to answer?	
150	What is the call abandonment rate?	

MEDICAL QUESTIONNAIRE		
Carrier Name		**ABC Company**
The following questionnaire must be completed.		
151	What are the YTD results for your call abandonment rate?	
	Misc.	**Response**
152	Review inforce SPD and indicate any provisions you cannot accommodate on the "SPD" deviations / variations page. If there are NO deviations listed we will assume the plan can be duplicated in its entirety.	Please Select

Vendor Name	ABC Company

For any benefits you cannot duplicate or administer, per the in force SPD, please indicate on this tab. Please clearly note the differences.

Proposed Medical -- Deviations/Variations

Please Select the Appropiate Category for each Deviation / Variation	Deviation / Variation
Please Select	
Please Select	
Please Select	
Please Select	
Please Select	
Please Select	
Please Select	

Vendor Name	ABC Company

Please note that you must include this information in the following requested formats in order for your quote to be considered. Enter only the network information that is included in your quoted rate.

If offering options, please create an additional tab and clearly label.

Medical Network Discounts

Please provide your organization's self reported discounts within the Client's area for:

Hospital Inpatient	
Hospital Outpatient	
Physician	

Geo Access Results

Please provide full detailed reports for the medical GEO access within your formal proposal.

Measurement	Primary Care Physicians	Specialists	Acute Care Hospitals
# of Employees / Zip Codes Evaluated			
Providers			
# of Providers			
# of Locations			
X Providers within X Miles	2 / 10	2 / 15	1 / 20
% of Employee WITH access			
# of Employees WITH access			
% of Employee WITHOUT access			
# of Employees WITHOUT access			
Average distance to 2 providers for employees WITH desired access			
Average distance to 2 providers for employees WITHOUT desired access			

Carrier Name

Please note that you must complete plan design and rate information in the following requested formats in order for your quote to be considered. Enter only those plan design elements that are included in your quoted rates.

If offering options, please add in additional columns and clearly label

Proposed Self-Funded Administration Fees

Enrollment Assumptions					
Employees					
Dependents					

Administrative Fee Breakdown (PEPM)	Year 1 - Mature Fees (run out administration included)	Year 2 - Mature Fees (run out administration included)	Year 3 - Mature Fees (run out administration included)	Year 4 - Mature Fees (run out administration included)	Year 5 - Mature Fees (run out administration included)
TOTAL PEPM Admin Fee (with Rx included)					
TOTAL PROJECTED ANNUAL ADMIN. FEES (with Rx included)	$0.00	$0.00	$0.00	$0.00	$0.00
TOTAL PEPM Admin Fee (without Rx included)					
TOTAL PROJECTED ANNUAL ADMIN. FEES (without Rx included)	$0.00	$0.00	$0.00	$0.00	$0.00
Required Administrative Fee Breakdown	Note: All services indicated below MUST be included within the total PEPM Admin fee above for your quote to be considered.				
1 Claims Processing	Please Select	Please Select	Please Select	Please Select	Please Select
2 Utilization and Case Management	Please Select	Please Select	Please Select	Please Select	Please Select
3 Network Administration / Access Fee	Please Select	Please Select	Please Select	Please Select	Please Select
4 Enrollment / Eligibility System Access	Please Select	Please Select	Please Select	Please Select	Please Select

5	**Directories / Fulfillment**	Please Select	Please Select	Please Select	Please Select	Please Select
6	**Reporting Access**	Please Select	Please Select	Please Select	Please Select	Please Select
7	**Booklet / SPD Printing & Distribution**	Please Select	Please Select	Please Select	Please Select	Please Select
8	**Initial ID Cards / Replacement Cards**	Please Select	Please Select	Please Select	Please Select	Please Select
9	**Banking Charges / Fees**	Please Select	Please Select	Please Select	Please Select	Please Select
10	**Standard or Electronic Reporting**	Please Select	Please Select	Please Select	Please Select	Please Select
11	**Centers of Excellence**	Please Select	Please Select	Please Select	Please Select	Please Select
12	**Physician Review and Medical Claim Review**	Please Select	Please Select	Please Select	Please Select	Please Select
13	**Explanation of Benefits (EOB)**	Please Select	Please Select	Please Select	Please Select	Please Select
14	**Integration with 3rd Party PBM (including accepting file feeds)**	Please Select	Please Select	Please Select	Please Select	Please Select
16	**Send monthly Medical/Eligibility Claim files to 3rd party**	Please Select	Please Select	Please Select	Please Select	Please Select
17	**Coordination of Benefits**	Please Select	Please Select	Please Select	Please Select	Please Select
18	**Behavioral Health Management (Mental Health and Substance Abuse)**	Please Select	Please Select	Please Select	Please Select	Please Select
19	**Integration of ongoing external pharmacy vendor data into predictive model**	Please Select	Please Select	Please Select	Please Select	Please Select
20	**Appeals and 3rd party external review**	Please Select	Please Select	Please Select	Please Select	Please Select

	Additional Fees and Services	PEPM	PEPM	PEPM	PEPM	PEPM
21	Stop Loss Reporting to a 3rd party					
22	Wellness Portal Allowance (to be used with carrier's product or a 3rd party solution)					
23	Implementation Allowance					
24	Wellness Allowance					
25	Access to the Tiered Network					
26	Disease Management					
27	Send lab values to 3rd party / Send preventive care visit aggregate data to 3rd party					
28	Customization of ID cards					
29	Non-Erisa plan charge					
	Additional Guarantees	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
30	Discount Guarantees					
31	Implementation Guarantees					
32	Performance Guarantees					

Other Set-Up, If Applicable	
Subrogation Percentage	
Shared Savings (must specifically outline the shared savings program include percentage of savings and caps)	
Initial Set-Up Charges (Enter amount)	
Capitated Charges (must specifically outline what the capitated fees are for)	
Run-out	

Assumptions

Net Commissions	

Carrier Name

Please note that you must complete plan design and rate information in the following requested formats in order for your quote to be considered. Enter only those plan design elements that are included in your quoted rates.

If offering options, please add in additional columns and clearly label.

Proposed Self-Funded Administration Fees

SPECIFIC RETENTION	Lives
Contract	
Coverages	
Annual/Policy Period Maximum Reimbursement	Unlimited
Maximum Lifetime Reimbursement	Unlimited
Specific Rates	
Single	
Family	
Composite	-
Monthly Premium	$0
Annual Premium	$0
AGGREGATE RETENTION	
Maximum Annual Reimbursement	
Aggregate Factors	
Composite	
Single	
Family	
Monthly Attachment Factor	$0
Annual Attachment Factor	$0
Aggregate Rates	
Rate - Composite	
Monthly Premium	
Annual Premium	$0

Total Monthly Fixed Costs	**$0.00**
ANNUAL PLAN FUNDING	
Fixed Expenses	$0
Expected Claims	$0
Total Laser Liablity	
MAXIMUM PLAN COSTS	**$0**

PHARMACY QUESTIONNAIRE

Vendor Name		ABC Company

The following questionnaire must be completed.

PBM carriers are required to respond to all requests for information contained in this questionnaire. This questionnaire will be scored; therefore, it is necessary that you provide concise answers. Your responses to the questions should be based on your current proven capabilities. Should there be instances where certain questions are not applicable to your organization or its operations, please indicate this. If you are selected to administer this plan, your responses to the questionnaire will be considered part of your contractual responsibilities. You are also requested to return the indicated exhibits as part of your proposal.

Answers should not exceed the allotted space within the cell(s) provided. DO NOT add extra rows/columns. Additional information in carrier format may be submitted if a carrier would like to include more detailed information.

Transparency Pricing		Response
1	The client is soliciting a **Transparent** Rx Pricing model. Is your proposal transparent?	Please Select
Pass Through of 100% of ALL Pharmaceutical Manufacturer Revenue (Required)		**Response**
2	The PBM agrees to pass through to the client 100% of any and all formulary rebates, market-share rebates, and other rebate revenue that the client's utilization enables the PBM to earn.	Please Select
3	The PBM agrees to pass through to the client 100% of any and all rebate administrative fees/credits that the client's utilization enables the PBM to earn.	Please Select
4	The PBM agrees to pass through to the client 100% of any and all data aggregation payments or data sale revenue that the client's utilization enables the PBM to earn, or to allow client to opt-out of these programs.	Please Select
5	The PBM agrees to pass through to the client 100% of any and all pharmaceutical manufacturer revenue associated with compliance and adherence programs that the client's utilization enables the PBM to earn, or to allow client to opt-out of these programs.	Please Select
6	The PBM agrees to completely disclose to the client any other revenue received directly or indirectly from pharmaceutical manufacturers that can not be attributed to specific client utilization. The PBM agrees that this disclosure will occur quarterly.	Please Select
Specialty Pharmacy Transparency (Required)		**Response**
7	The PBM agrees to pass through to the client any and all pharmaceutical manufacturer revenue that the client's specialty pharmacy utilization enables the PBM to earn.	Please Select
8	The PBM agrees to charge a client no more than the acquisition cost of drugs at the specialty mail order pharmacy, plus a dispensing fee. Any retail claims for specialty pharmacy shall be adjudicated under the same logic as the traditional retail pricing agreed upon in the Retail Network certification requirements. This protocol does not include any commitments as it pertains to specialty products dispensed and billed under the medical plan or home infusion benefit.	Please Select
9	The PBM agrees to provide dose optimization and consolidation programs, where appropriate.	Please Select

PHARMACY QUESTIONNAIRE		
Vendor Name		**ABC Company**
The following questionnaire must be completed.		
10	The PBM agrees to provide case management for critical disease states (as designated by mutual agreement between the client and the PBM), and will agree not to build the cost of these programs into drug ingredient cost.	Please Select
Organizational Strength		**Response**
11	How many clients do you currently have inforce in the state of Texas?	Please Select
12	Do you have a specialized team that works with public entity employers?	Please Select
13	How many clients do you currently have in Texas that are public entities?	
Implementation Process		**Response**
14	Will you have an onsite representative available for annual open enrollment meetings as requested by the client?	Please Select
15	Will you peform a pre-implementation claims audit of the system and share the results with the client before accepting claims?	Please Select
Claims Administration		**Response**
16	Please attach a sample of your Administrative Services Agreement.	Please Select
17	Describe how your systems are integrated, specifically related to enrollment, medical/referral/authorization, provider, contracts and claims.	
18	Describe how you will actively manage the pharmacy claims for this client. Our goal is that the PBM will provide a proactive approach to replacing high cost drugs and highly utilized drugs with generic alternatives. This approach should include sending an email or setting up a call with the client to discuss the options available.	
19	Will the client have a dedicated claims analyst that the client's HR team can contact with questions?	Please Select
20	Do you agree to send a monthly **claims file** to the consultant and a 3rd party? If so, please include this cost on the Pricing Spreadsheet	Please Select
21	Are you able to send a monthly claims file to the medical carrier for the purposes of Care management and integrating the Rx claims in the maximum out of pocket maximum?	Please Select
22	The PBM agrees to notify the client of any drug, including speciality drugs over $5,000 per script within ONE BUSINESS WEEK of being dispensed. The PBM will contact the client notifying them of the type of drug, alternative options, if it is an FDA approved drug and if any outreach to the individual has occured. The overall goal is to ensure that there is active management of the client's pharmacy claims.	Please Select
Reporting		**Response**
23	Please include samples of standard management/financial reports.	Please Select
24	What is the standard distribution frequency for each report provided?	Please Select
25	Do you agree to send a monthly **Executive summary** to the client? This should at least include: Rolling trend, top 10 drugs by spend, top 10 drugs by utilization, maintenance drug fill rates, and generic utilization.	Please Select
26	Please attach a sample of your monthly Executive summary report.	Please Select
27	Do you agree to send standard reports, including enrollment, utilization and large claims, on a monthly basis to both the client and the consultant?	Please Select
28	Do you agree to have a quarterly meeting with the client and provide actionable information based on the claims activity?	Please Select

PHARMACY QUESTIONNAIRE		
Vendor Name		**ABC Company**
The following questionnaire must be completed.		
29	Do you agree to provide disease specific fill rates on medications?	Please Select
30	What is the process for requesting ad hoc reports?	
31	Is there a fee charged for ad hoc reports?	Please Select
32	If so, what is the fee?	
33	What is the standard turn around time for ad hoc reports?	
General		**Response**
34	Do you agree to allow the client to send a weekly ACH transfer or a check for the claims?	Please Select
35	Do you require the customer to have an imprest balance?	Please Select
36	Do you have a mail order program?	Please Select
37	Who administers your mail order pharmacy program?	
38	Describe how your specialty drug program works and how you are able to lower costs?	
39	Are you able to accommodate a plan design that allows 90 day retail at any pharmacy location?	Please Select
40	Are you able to set up your plan with zero dollar logic? For example, we are looking for a plan that will adjudicate a claim at a lower price than the plan's copay IF the cost of that drug is less than the actual plan copay.	Please Select
41	What is the name of your primary network?	
42	How many MAC lists do you utilize?	
43	Please attach a copy of MAC list(s) proposed for this client.	Please Select
44	Will the client receive 100% of the rebates?	Please Select
45	At what frequency will the client receive rebate checks?	
46	Please attach a copy of your formulary list.	Please Select
47	How often do you change your formulary?	Please Select
48	Are you able to administer limited network Rx plans?	Please Select
49	If so, is there an additional cost?	Please Select
50	What are the potential estimated savings by implementing a limited network for this client?	
51	Confirm that you have reviewed the Pharmacy SPD and can administer all benefits, programs, limits and exclusions as stipulated in the document. (**Note - If you cannot accommodate a benefit, program, limit or exclusion please list it out specifically on the Deviations-Variations tab.)**	Please Select
52	Do you have any benefits, programs, limits or exclusions that you cannot accommodate and will be adding to the Deviations-Variations tab?	Please Select
Clinical Programs		**Response**
Please describe your approach to the programs below, and indicate potential cost savings to the client. Note - Please see the tab labeled " PBM - Clinical Programs" to see the programs currently in place for the City		
53	Quantity Level Limits	
	Annual Potential client savings	

PHARMACY QUESTIONNAIRE		
Vendor Name		**ABC Company**
The following questionnaire must be completed.		
54	Quantity Per Duration Limits	
	Annual Potential client savings	
55	Step Therapy Program	
	Annual Potential client savings	
56	Medication Adherence Notification Program	
	Annual Potential client savings	
57	Mandatory Generic program	
	Annual Potential client savings	
58	Therapeutic Interchange	
	Annual Potential client savings	
59	OTC Switch Program	
	Annual Potential client savings	
60	Retrospective DUR	
	Annual Potential client savings	
61	Concurrent DUR	
	Annual Potential client savings	
62	Prior Authorization	
	Annual Potential client savings	
63	Disease Management Programs	
	Annual Potential client savings	
64	Additional Client Recommendations	
	Annual Potential client savings	
Specialty Pharmacy Management		**Response**
65	What kind of ongoing disease education is available?	
66	How is the effectiveness of the treatment monitored?	
67	What kind of adherence and persistence outreach is performed?	
68	How do you manage adherence and mitigate drug waste?	
69	Are proactive refill reminders offered?	Please Select
70	Does the pharmacy only focus on specialty?	Please Select
71	How is shipping managed/monitored?	
72	Is First In First Out (FIFO) pricing practiced?	Please Select
73	Is there a pharmacist available 24/7 for questions?	Please Select
74	How is care coordinated with physicians?	
75	What types of Clincal pathways are in place?	

PHARMACY QUESTIONNAIRE		
Vendor Name		**ABC Company**
The following questionnaire must be completed.		
76	What Prescriber support services are available?	
77	How are speciality products selected?	
78	Are you nationally accredited?	Please Select
79	How is insurance, including reimbursement and copay assistance handled?	
Plan Management & Consumer Engagement		**Response**
80	The PBM agrees to allow customization or modification of the client's formulary or preferred drug list (PDL) at the client's discretion (with the understanding that such modifications may impact minimum rebate pricing guarantees).	Please Select
81	The PBM agrees to meet with the client on a quarterly basis and provide reporting on Rx trends, fill rates, cost saving opportunities and updates on the care management.	Please Select
Comprehensive Audit & Disclosure Rights		**Response**
82	The PBM agrees to grant the client full rights to audit their pharmacy claims utilization data, contracts and arrangements with retail network pharmacies, contracts and arrangements with pharmaceutical manufacturers, PBM revenue streams tied to client spending, and clinical criteria for utilization management programs.	Please Select
83	The PBM agrees not to limit the client's selection of an auditor to a list of specific firms. However, language specifying "mutually agreeable" selection of an audit firm is permissible.	Please Select
84	The PBM agrees to allow a client to self-audit (conduct an audit without using a third-party audit firm) as long as there is an established "Business Controls" area within the specific Groups organization, and there is no clear conflict of interest inherent in a self-audit.	Please Select
85	The PBM agrees to provide complete claims data files to the client or their designated consultant or third-party provider upon the client's request, including all financial data fields (Undiscounted AWP, Discounted Ingredient Cost, Billed Amount, Dispensing Fee and, if available, POS Rebates and Wholesale Acquisition Cost).	Please Select
Other Relevant Contracting Considerations		**Response**
86	The PBM agrees that the financial guarantees that the PBM provide to the client will each function on an independent basis, and that the PBM will not use an overage from one guarantee (i.e. generic mail order discount) to offset a shortfall from another guarantee (i.e. brand mail order discount).	Please Select

Vendor Name	ABC Company

For any benefits or terms from the Questionairre that you cannot duplicate or administer, please indicate on this tab. Please clearly note the differences.

Proposed PBM-- Deviations/Variations

Please Select the Appropiate Category for each Deviation / Variation	Deviation / Variation
Please Select	
Please Select	
Please Select	
Please Select	
Please Select	
Please Select	
Please Select	

Vendor Name	ABC Company

Please note that you must include this information in the following requested formats in order for your quote to be considered. Enter ONLY the networks that are included in your quoted rates.

Pharmacy Geo Access Results

Please provide full detailed reports for the GEO access within your formal proposal.
If offering options, please add in additional columns and clearly label them.

Measurement	Pharmacies
# of Employees / Zip Codes Evaluated	
Providers	
# of Providers	
# of Locations	
X Providers within X Miles	2 / 10
% of Employee WITH access	
# of Employees WITH access	
% of Employee WITHOUT access	
# of Employees WITHOUT access	
Average distance to 2 providers for employees WITH desired access	
Average distance to 2 providers for employees WITHOUT desired access	

Vendor Name

Please note that you must complete fee information in the following requested format in order for your quote to be considered. Enter only those elements that are included in your quoted fees.

Pricing - Annualized	Year 1
Projected Paid Claims	
Electronic Reporting – Full Access at Highest Level	
Outbound Data Feeds- up to 2 Third Parties	
Set-up Charges	
Additional Fees - Describe	
Rate Guarantee	
Clinical Savings Programs- Cost per program annualized	**Year 1**
Quantity Limits	
Step Therapy Program	
Therapeutic Interchange	
Medication Adherance with Dr. Notification	
Mandatory Generic Program	
OTC Switch Program	
Retrospective DUR	
Concurrent DUR	
Prior Authorization	
Disease Management Programs	
Additional Client Recommendations	

Contractual Components		
Retail		**Year 1**
Brand Name Formulary:	AWP -	
Brand Name Non-Formulary:	AWP -	
Brand Dispensing Fee		
Generic:	MAC Pricing or AWP -	
Generic Dispensing Fee		
Admin Fee		
Confirm if AWP is pre or post		Please Select
Narrow Retail Network (if available)		**Year 1**
Brand Name Formulary:	AWP -	
Brand Name Non-Formulary:	AWP -	
Brand Dispensing Fee		
Generic:	MAC Pricing or AWP -	
Generic Dispensing Fee		

Admin Fee		
Confirm if AWP is pre or post		Please Select
Mail Order		
Brand Name Formulary:	AWP -	
Brand Name Non-Formulary:	AWP -	
Brand Dispensing Fee		
Generic:	MAC Pricing or AWP -	
Generic Dispensing Fee		
Rebates		
Estimated rebate per script based on current plan design and utilization		