**SECTION V: Response Forms**

**Exhibit I: Medical Plan Response Form – Please Complete Below Form**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Current** | | **Proposed – Please Match as Closely As Possible** | |
| **Schedule of Benefits** | **Cigna OAP Plan** | |  | |
| **Network Utilized:** | **Open Access Plus** | |  |  |
| **Calendar Year Deductible (CYD)** | **In Network** | **Out of Network** | **In Network** | **Out of Network** |
| Single | $2,000 | $2,000 |  |  |
| Family | $4,000 | $4,000 |  |  |
| Coinsurance | 10% | 30% |  |  |
| **Calendar Year Out of Pocket** |  |  |  |  |
| Single | $3,500 | $3,500 |  |  |
| Family | $7,000 | $7,000 |  |  |
| **Physician Services** |  |  |  |  |
| Primary Care Physician (PCP) Visit | $20 Copay | 30% after CYD |  |  |
| Specialist Office Visit | $40 Copay | 30% after CYD |  |  |
| Telehealth Services | No Charge | Not Covered |  |  |
| **Non-Hospital Services** |  |  |  |  |
| Clinical Lab (Bloodwork) | No Charge | 30% after CYD |  |  |
| X-Rays/Advanced Imaging | No Charge | 30% after CYD |  |  |
| Outpatient Surgery in Surgical Center | 10% after CYD | $300 + 30% after CYD |  |  |
| Outpatient Physician Services | 10% after CYD | 30% after CYD |  |  |
| Urgent Care Center | $75 Copay | $75 Copay |  |  |
| **Hospital Services** |  |  |  |  |
| Inpatient | 10% after CYD | $500 + 30% after CYD |  |  |
| Physician Services at Hospital | 10% after CYD | 30% after CYD |  |  |
| Emergency Room | $150 | $150 |  |  |
| Ambulance | 10% after CYD | 10% after CYD |  |  |
| **Outpatient Rehabilitation** |  |  |  |  |
| Facility Charge | $40 Copay | 30% after CYD |  |  |
| **Mental Health/Substance Abuse** |  |  |  |  |
| Inpatient | No Charge | 30% |  |  |
| Outpatient Facility | $10 Copay | 30% |  |  |
| **Prescription Drugs** |  |  |  |  |
| Generic | $10 Copay | 30% |  |  |
| Preferred Brand Name | $30 Copay | 30% |  |  |
| Non-Preferred Brand Name | $50 Copay | 30% |  |  |
| Mail-Order Drug (90 Day Supply) | 2x Retail | Not Covered |  |  |
| **Monthly Premium Equivalents** | **Current** | | **Provide Recommended Premium Equivalents Below** | |
| Employee Only | $774.45 | |  | |
| Employee + One | $1,326.99 | |  | |
| Employee + Family | $2,177.41 | |  | |

**SECTION V: Response Forms**

**Exhibit II: Medical Administrative Services Only Response Form – Please Complete Below Form**

|  |  |
| --- | --- |
| **Administrative Services Only** | **Proposed** |
| **ASO Fee Components** |  |
| Name of Proposer |  |
| Name of Network(s) Utilized |  |
| Administration Fee (PEPM) |  |
| Utilization Review (PEPM) |  |
| Network Access Fee (PEPM) |  |
| Disease Management (PEPM) |  |
| Pharmacy Management Fee (PEPM) |  |
| Wellness Program Fee (PEPM) |  |
| HIPAA Certification |  |
| COBRA Administration (PEPM) |  |
| Other Fees (PEPM) |  |
| Termination Fees (PEPM) |  |
| Rate Guarantee |  |
| **TOTAL ADMIN FEE (PEPM) Year 1** |  |
| **TOTAL ADMIN FEE (PEPM) Year 2, if applicable** |  |
| **TOTAL ADMIN FEE (PEPM) Year 3, if applicable** |  |
| **TOTAL ADMIN FEE (PEPM) Year 4, if applicable** |  |
| **TOTAL ADMIN FEE (PEPM) Year 5, if applicable** |  |

**SECTION V: Response Forms**

**Exhibit III: Pharmacy Benefits Management Response Form – Please Complete Below Form**

|  |  |  |
| --- | --- | --- |
| **Pharmacy - Discounts, Fees, and Rebate Sharing** | **Description** | **Proposed** |
| **Pharmacy Network Information** |  |  |
| Network Size (Number of Network Pharmacies) | **-** |  |
| Major Retail Pharmacies Excluded from Network | **-** |  |
| **Admin Fees** |  |  |
| Per Script Administrative Fee (Retail and HD) | Per paid script |  |
| PEPM Administrative Fee | PEPM |  |
| **Retail Discounts and Fees (30 day)** |  |  |
| Retail Brand Discount | AWP |  |
| Retail Generic Discount | AWP |  |
| Retail Dispensing Fee Brand | Per script |  |
| Retail Dispensing Fee Generic | Per script |  |
| **Retail Discounts and Fees (90 day)** |  |  |
| Retail Brand Discount | AWP |  |
| Retail Generic Discount | AWP |  |
| Retail Dispensing Fee Brand | Per script |  |
| Retail Dispensing Fee Generic | Per script |  |
| **Mail Order Discounts and Fees** |  |  |
| Cigna Home Delivery Brand Discount | AWP |  |
| Cigna Home Delivery Generic Discount | AWP |  |
| Cigna Home Delivery Dispensing Fee  (including specialty) | Per script |  |
| **Specialty Discounts and Fees** |  |  |
| Specialty Retail Brand Discount | AWP |  |
| Specialty Retail Brand Dispensing fee | Per script |  |
| **Rebate Sharing** |  |  |
| Retail 30 | Per Brand |  |
| Retail 90 | Per Brand |  |
| Mail Order | Per Brand |  |
| **Estimated Rebates\*** |  |  |
| **Total Estimated Annual Rebates** | **Please Include Projected Rebates:** |  |

**SECTION V: Response Forms**

**Exhibit IV: Stop Loss Insurance Response Form – Please Complete Below Form**

|  |  |  |
| --- | --- | --- |
| **Stop Loss Insurance** | **Current** | **Proposed** |
| **Specific Stop Loss** |  |  |
| Individual Pooling Point | $250,000 |  |
| Tiered Pooling Point | $350,000 |  |
| Tiered Pooling Cost Share | 50% |  |
| Run In Cap (Per Participant) | N/A |  |
| Laser(s) | None |  |
| Benefits Covered | Medical/MHBH/Rx |  |
| Contract Basis | 12/36 |  |
| Annual Maximum Reimbursement | Unlimited |  |
| Composite Specific Stop Loss PEPM | $72.65 |  |
| **Other Terms** |  |  |
| Please Confirm your quote does Not  include Aggregate Stop Loss Coverage | Does Not Include |  |
| Are Retirees Covered? | Yes |  |
| Are Proposed Stop Loss Fees Firm? | N/A |  |
| *If you are unable to quote the same tiered stop loss, please quote a $300k ISL* | | |

**SECTION V: Response Forms**

**Exhibit V: Employee Assistance Program Response Form – Please Complete Below Form**

|  |  |
| --- | --- |
| **EAP VENDOR NAME:** | **Provide Vendor Name Here** |
| **Eligibility** |  |
| Please define Eligibility: (EE, Retiree, Dep, Household Members) |  |
| **Core Benefits** |  |
| Number of Face-to-Face Visits Included: |  |
| Number of Telephonic Visits Included: |  |
| 24/7 Counseling Available Telephonically? |  |
| **Onsite Hours** | **Please specify if different buckets** |
| Onsite Hours Included in Proposal: |  |
| Onsite Hours Hourly Rate: |  |
| **First Responder/CISD Assistance** |  |
| Will First Responders be identified upon calling? |  |
| Critical Incident Stress Debriefing (CISD) Pricing |  |
| Fitness for Duty Evaluation/Referrals |  |
| **Services/Materials included in Pricing** |  |
| Online Resources |  |
| Mobile App Included? |  |
| Webinars Included? |  |
| Management Referrals & Training |  |
| Brochures & Workplace Posters |  |
| Referrals to Community Service |  |
| Substance Abuse Assistance & Referrals |  |
| Legal Assistance & Referrals |  |
| Financial Assistance & Referrals |  |
| Child Care/Elder Care Assistance & Referrals |  |
| **Network Details** | **# Providers in your Network/ County** |
| Pinellas County |  |
| Pasco County |  |
| Hillsborough County |  |
| Manatee County |  |
| Willing to Network outreach to non-contracted providers? |  |
| **Other** |  |
| Utilization Reporting Frequency |  |
| Designated Account Manager Included in Proposal? |  |
| Levels of Education of Telephonic Consultants? |  |
| Licenses, Degrees, and Certifications of Local Panel Providers? |  |
| **Rate Guarantee?** |  |
| Rate (PEPM) |  |

**SECTION VI: Questionnaires**

**Questionnaire - General Information**

1. Are you willing to provide performance guarantees for implementation and servicing of your products? If so, please describe the performance guarantees you are proposing.

2. Please indicate the group name, address, contact person, and telephone number of up to three firms in Florida to whom your company has forfeited money because of service problems in the last three years.

3. Do you agree to allow retirees over and under 65 to continue coverage under the same plan at the same rate as active employees as required by Section 112.08, Florida Statutes, for public entities?

4. Provide the name, title, and contact information of the individual who would have direct daily account responsibility for the services you are proposing. If more than one person will be filling this role, please respond with complete information for all.

5. Provide the name, title, and contact information for three (3) references from public entity clients with a minimum of 2000 employees for at least three (3) years immediately preceding the response due date.

|  |  |  |  |
| --- | --- | --- | --- |
| **References** | **Reference 1** | **Reference 2** | **Reference 3** |
| **Group Name** |  |  |  |
| **Contact Name** |  |  |  |
| **Contact Title** |  |  |  |
| **Contact Phone** |  |  |  |
| **Contact Email** |  |  |  |
| **Coverage/Services Provided** |  |  |  |
| **Length of Time** |  |  |  |

**SECTION V: Response Forms**

**Exhibit VI: Questionnaire - General Information**

6. What is your account service team’s average response time to client requests or questions?

7. Describe the services provided by your account service team to the employees.

8. Describe the services provided by your account service team to the Human Resources department.

9. Does your company help facilitate annual open enrollments? a. Onsite meetings? b. Educational materials? c. Printed Materials at no cost?

10. What is your company’s current A. M. Best, Moody’s and/or Standard and Poor’s ratings?

11. Do you utilize any “wrap” or leased networks not negotiated or owned by your company? If yes, what is the name of the network?

12. Describe capabilities available through member website and mobile app. Please describe further any additional functionality available to employer as plan administrator.

13. Please specify if proposer is SSAE 18 / SOC / SAS certified.

**Exhibit VI: Questionnaire - Data and Reports**

1. Describe the reports you will provide regarding the utilization and claims associated with the employee benefits program(s) you are proposing. Please indicate in your description if any of the reports would be provided at an additional cost over the fees associated with the programs.

2. What is your proposed frequency of reporting on utilization experience? Is there a charge for utilization data analysis?

3. Are there any additional fees for reporting? Please provide all reporting options/packages and their associated costs.

4. Will there be online access for claim reports?

5. How often are claim audits conducted and what percentage of claims are audited? If you use a third-party to audit claims, please disclose the name of auditor.

6. How do you identify fraudulent claims and how will you notify the entity?

7. Describe the process for identifying and paying claims which may be subject to subrogation.

8. Will there be online access for claim reports by the Entity and Gehring Group?

**SECTION V: Response Forms**

**Exhibit VI: Questionnaire - Implementation and Billing**

1. Please provide a brief description of the implementation process, including requirements and timeline.

2. Please confirm proposer is flexible to modify standard contract language.

3. Please confirm proposer is willing to waive binder payment requirements.

4. Please confirm proposer is willing to accept a self-bill for proposed line(s) of coverage.

5. What is proposer's standard billing snapshot date and grace period for payment?

**Exhibit VI: Questionnaire - Renewal Planning and Additional Fees**

1. Is proposer willing to provide renewal offer at least 180 days prior to renewal effective date?

2. Are any of the rates proposed contingent on any additional information? If so, please disclose.

3. What additional services are available and at what cost?

4. Would you allow a grace period after the due date of 45 days for payment of an invoice?

5. Please confirm any bundling discounts you are offering here.

**SECTION V: Response Forms**

**Exhibit VI: Questionnaire - Enrollment & Implementation Technology**

1. Does your company (or third-party) process electronic eligibility files via automation or are manual steps necessary? If manual steps are required to process files, please explain this process and impact on processing time.

2. Does your company outsource the processing of electronic eligibility to a third-party? If so, please provide company name.

3. Please specify if your company (or third-party) accepts the HIPAA 834 5010 file layout as well as all other file layouts accepted for automated enrollment. Please provide applicable coding supplements and other applicable file specification documents.

4. What is your company's (or third-party's) standard processing time for electronic eligibility to be updated in all applicable internal systems (eligibility/claims/billing/etc.)? If time varies, please specify for each system.

5. Will your company (or third-party) provide confirmation notification to the group when files are processed? Please provide details related to this notification process (email, requirement of group log into company website, etc.)

6. Please provide implementation time (in days) for initial set-up of automated enrollment (electronic eligibility) of an established group with your company.

7. Please provide implementation time (in days) for initial set-up of automated enrollment (electronic eligibility) of a new group with your company.

8. Please provide set-up time needed for changes to file structure, plans, funding strategy, platform changes for an established group with your company. What alternative options does your company provide to receive enrollment should these changes cause delay in set-up of the EDI process?

9. Please provide file testing time frame (in days) for initial set-up and structure changes.

10. Please provide the standard time frame required to process files, generate, and mail member ID cards. What options does the group have if ID card delivery is delayed beyond the plan effective date?

**SECTION V: Response Forms**

**Exhibit VI: Questionnaire - Medical**

1. Please provide a Medical Geo Access report that illustrates the number of: a. 1 Hospital within 10 miles b. 2 PCPs & Pediatricians within 10 miles c. 2 OBs/Gyns, within 10 miles d. 2 Specialists within 10 miles (excluding OBs/Gyns) e. 2 Urgent Care Centers within 10 miles The report format should include a breakdown by employee city of residence with the number of employees in that location and the number of providers servicing that location. The report should also include reporting on the number and location of employees who do not meet the above criteria.

2. Please confirm average discounts for the geographic area represented in employee/member census as follows:  
Please provide this information for the following counties in order: Pinellas County, Hillsborough County, Pasco County, Manatee County, Hernando County.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Charge Type** | **Pinellas County** | **Hillsborough County** | **Pasco County** | **Manatee County** | **Hernando County** |
| **Location** |  |  |  |  |  |
| **Doctors** |  |  |  |  |  |
| **Urgent Care Centers** |  |  |  |  |  |
| **Out-Patient Hospital** |  |  |  |  |  |
| **In-Patient Hospital** |  |  |  |  |  |
| **All Others** |  |  |  |  |  |

**SECTION V: Response Forms**

**Exhibit VI: Questionnaire - Medical**

3. Please identify proposed provider network.

4. For bidders not proposing national network coverage, please describe available access for out-of-state residents (retirees and/or dependents of covered participants).

5. Is proposer willing to provide performance guarantees for your network discounting? If so, please include details.

6. Please confirm requirements for coordination with Medicare for both active employees and their dependents, as well as retired employees and their dependents.

7. Each proposer must confirm that they will provide the following reports upon request (possibly quarterly) by the Entity or its Agent of Record: a. Large Claimants (over $25,000) inclusive of gender, plan, diagnosis, last date of service, prognosis and if the claimant remains covered on the plan. b. Utilization reports by diagnosis, place of service, employee vs. dependent costs. c. Monthly paid claims.

8. Are you willing to conduct face-to-face meetings annually (including medical/pharmacy director and financial analyst support) with the client to discuss financial and program enhancement/cost containment ideas that will assist the client in benefit design strategy, and will not necessarily be focused on plan design coverage reductions?

9. Are you willing to waive the actively at work, dependent non-confinement limitation provisions for all currently enrolled individuals on medical?

10. Please list and describe your Disease Management programs that are included in proposal.

11. Please list and describe Utilization Management programs included in proposal and other available options, if applicable.

12. Please confirm dependent child(ren) eligibility.

13. Please confirm proposer has included telemedicine benefit in medical quote.

14. How do you handle transition of care for members currently undergoing treatment or have existing relationships with the incumbent carrier’s network providers?

15. Self-Insured: Provide recommended premium equivalents for the current plan designs shown in the medical benefit response form section.

16. Self-Insured: Please confirm if medical ASO quote is contingent upon bundled Stop Loss and/or PBM administration. If so, please confirm what is required to be attached and/or pricing differential without bundled administration.

**SECTION V: Response Forms**

**Exhibit VI: Questionnaire - Medical**

17. Self-Insured: Is your company willing to provide administrative fee guarantee? If so, please provide the details of your guarantee.

18. Please confirm you provided a response to the medical provider network disruption report indicating which of those medical providers are in or out of your proposed network.

19. Please confirm you provided a response to the prescription drug disruption report indicating which Pharmacy benefit tier each of the listed drugs is covered under or if they are not included in your formulary.

20. Please confirm the additional funds included in your proposal here including wellness funds, on-site wellness representative fund, employee wellness center fund, discretionary funds, or any other funds.

21. Is proposer willing to provide performance guarantees around Rx rebates? If so, please include details.

22. Please confirm your medical insurance proposal is submitted net of broker commissions.

**SECTION V: Response Forms**

**Exhibit VI: Questionnaire - Stop Loss**

1. Please confirm proposed quote is firm. If not, please provide details as to why.

2. Please confirm proposed quote contract terms.

3. Please confirm proposal does not include lasers.

4. Please confirm proposer’s process for inclusion of lasers, if applicable, at renewal.

5. Please detail data requirements in order to process reimbursements.

6. What is the period for reimbursements once the claim information is submitted for payment? Do you offer Advanced Funding on claims reimbursements at no cost to the client?

7. Please confirm that proposer will base stop loss coverage reimbursements on the ‘Eligible Expenses’ as defined by the medical ASO plan document.

8. Does proposal exclude any member population included in census?

9. If proposer is awarded the Stop Loss insurance contract, please confirm if policy is guaranteed renewable.

10. How many months of current year experience are required to offer a firm renewal?

11. Upon underwriting approval, does proposer offer a maximum renewal rate cap on specific rates?

12. Please confirm if your stop loss proposal matches the City’s current ISL layout ($250k ISL/$350k ISL with 50% cost share). If you are unable to quote this option please confirm you are quoting a $300k ISL.

13. Please confirm your stop loss proposal does not include aggregate stop loss coverage.

**SECTION V: Response Forms**

**Exhibit VI: Questionnaire - Wellness**

1. Please disclose the name of your proposed wellness program and any wellness funds you are offering the City.

2. Did proposer include the criteria associated with how the Entity can use the wellness funds?

3. Are there any additional costs to the Entity or employees for participation in your wellness programs or services?

4. Will the account team assigned include a designated wellness coordinator? If so, which wellness services will be included?

5. Does your company offer rate discounts on the proposed programs, in dollars or percent, to employer groups who implement an active, participatory Wellness Program? If so, please describe the discount model amount and requirements.

6. Does your wellness program provide a proactive health education and improvement program for those with a chronic condition?

7. Does your wellness program utilize behavioral coaching principles and evidence-based medicine guidelines to optimize self-management skills to foster sustained health improvement?

8. Does your wellness program include: a. Chronic condition-specific coaching? b. Pre- and post-discharge calls? c. Lifestyle management coaching: stress, weight management, and tobacco cessation? d. Treatment decision support and coaching?

**SECTION V: Response Forms**

**Exhibit VII: Other Required Forms**



**SECTION V: Response Forms**

**Exhibit VII: Other Required Forms**



**SECTION V: Response Forms**

**Exhibit VII: Other Required Forms**



**SECTION V: Response Forms**

**Exhibit VII: Other Required Forms**



**SECTION V: Response Forms**

**Exhibit VII: Other Required Forms**



**SECTION V: Response Forms**

**Exhibit VII: Other Required Forms**

