25-56 Addendum 2

SELF-FUNDED PLAN, CARRIER/THIRD PARTY ADMINISTRATOR (TPA), PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK, PHARMACY BENEFIT MANAGEMENT (PBM) SERVICES, TRANSPARENT MODELING AND OR PASS-THROUGH MODELING, INTERNATIONAL RX OPTION AND STOP LOSS COVERAGE

Issue Date: 4/7/2025
Questions Deadline: 4/30/2025 12:00 PM (CT)
Response Deadline: 5/7/2025 03:00 PM (CT)

Contact Information

Contact: CLAUDINA LONGORIA SENIOR BUYER
Address: 411 North 8th Ave.
Edinburg, TX 78539
Email: d.longoria@ecisd.us

Event Information

Number:	25-56 Addendum 2
Title:	SELF-FUNDED PLAN, CARRIER/THIRD PARTY ADMINISTRATOR (TPA), PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK, PHARMACY BENEFIT MANAGEMENT (PBM) SERVICES, TRANSPARENT MODELING AND OR PASS-THROUGH MODELING, INTERNATIONAL RX OPTION AND STOP LOSS COVERAGE
Type:	Request for Proposal
Issue Date:	4/7/2025
Question Deadline:	4/30/2025 12:00 PM (CT)
Response Deadline:	5/7/2025 03:00 PM (CT)

Notes:

GENERAL CONDITIONS AND RFP ASSUMPTIONS

The Edinburg Consolidated Independent School District is requesting proposals for Self-Funded Plan, Carrier/Third Party Administrator (TPA), Preferred Provider Organization (PPO) Network, Pharmacy Benefit Management (PBM) Services, Transparent Modeling and or Pass-Through Modeling, International Rx Option and Stop Loss Coverage. For the purpose of this RFP, the Edinburg Employee Benefit plan is considered “Grandfathered” under Affordable Care Act (ACA). TPA/Carriers, PPO’s, and PBM’s submitting proposals with bundled services should do so with the understanding that the District will be possibly considering entering into agreements on a direct basis with the service providers independent of the TPA/Carriers, PPO’s, and PBM’s to best serve the interest of the District.

Currently in place at ECISD: Blue Cross Blue Shield of Texas is the current Health TPA along with their BCBS network. Prime Therapeutics currently provides Pharmacy Benefit Management (PBM) Services. Companion Life is the current Stop Loss Carrier with a current coverage of $350,000 as the specific deductible and with a $165,000 aggregate deductible.

The District will not consider any “modified plans” or plans which are not ACA compliant.

All companies submitting proposals must be licensed by the Texas Department of Insurance and be permitted to contract with the State or any of its subdivisions. All insurance carriers must be rated A- or better by AM Best Company.

TPA/Carriers, PPO’s, and PBM’s submitting proposals should do so with the understanding that Edinburg CISD will only consider offers that include Fiduciary claims responsibility. It is further understood that awarded TPA/Carriers, PPO’s and PBM’s will agree to hold the ECISD harmless in the event of any IRS penalties or fines impose as of result of the TPA/Carriers, PPO’s, and PBM’s failure to comply with ACA Public Law.

TPA/Carriers, PPO’s, and PBM’s submitting proposals should do so with the understanding that ECISD will not agree to pay any additional fees, costs or expenses other than those expressly set forth in the proposal response in which ECISD will require the TPA/Carrier, PPO’s and PBM’s to certify that they will not receive any revenue or compensation for any other third party related to the services provided under the agreement except for the revenue and compensation expressly described in its proposal response form. Proposals must be clearly explained and identified. All costs including optional programs must be clearly stated and summarized. Exceptions or deviations from the specifications must be explicitly identified.

If submitting RFP documents manually One (1) original ring binder and one (1) copy of the proposal

response in USB format must be delivered to Amaro Tijerina, Director of Purchasing, c/o Edinburg Consolidated ISD, 411 N. 8th Avenue, Edinburg, Texas 78541, no later than 3:00 PM, Wednesday, May 7, 2025. Sealed envelopes must be clearly marked as follows:

RFP 25-56, Self-Funded Plan, Carrier/Third Party Administrator (TPA), Preferred Provider Organization (PPO) Network, Pharmacy Benefit Management (PBM) Services, Transparent Modeling and or Pass-Through Modeling, International Rx Option and Stop Loss Coverage

No telephone, fax or email proposals will be accepted. Proposals may only be accepted if delivered by U.S. Postal Services or other courier services including hand delivery or submitted electronically through the district's online portal IONWAVE. The District will not be responsible for missing, lost or late mail. Any proposals received after the time set for opening will be returned to the proposer unopened upon written request at proposer's expense.

The proposals will be opened at **3:00 PM, WEDNESDAY, MAY 7, 2025**. The proposals will be opened but not read aloud to avoid disclosure of contents to competing vendors and the contents shall be kept confidential during the proposal evaluation and negotiations.

Agent Commissions: The DISTRICT requests all proposals on a direct basis from the Vendor's. All Proposals are to be submitted NET OF ANY AGENT/ BROKER FEES or COMMISSIONS. AN AGENT OF RECORD LETTER WILL NOT BE ISSUED.

Proposals are desired for a primary term of one (3) year with the option to renew for five (5) additional one (1) year terms with a minimum of a 24-month rate guarantee (TPA/Carrier, PPO and PBM services). However, the Board of Trustees reserves the right to accept a guarantee of less than 24 months if it is in the District's best interest. All proposal terms and rates must be good for 120 days following the due date.

Public Sector employers are not allowed, under current state law, to execute a document containing a Hold Harmless/Indemnification Clause causing the employer to be responsible for other parties liability(ies). Therefore, your documents should not contain any such clauses.

Edinburg Consolidated Independent School District reserves the right to accept or reject all or any part of the proposal, waive minor technicalities and award the proposal that best serves the interest of the District. The District also reserves the right to waive or dispense with any of the formalities contained herein. The Edinburg CISD Board of Trustees will make the final decision on award.

Requests for information must be submitted via email to:

Dustin Garza, Insurance Manager
Edinburg Consolidated ISD
Dustin.garza@ecisd.us

COMMUNICATION WITH SCHOOL DISTRICT MEMBERS: Company and representatives submitting proposals shall not discuss this RFP with employees of ECISD or members of the Board of Trustees. Communication includes but is not limited to unsolicited literature, email, faxes or phone calls related to any aspect of the RFP. If discussion is necessary, you will be notified in writing by the individual listed above. Failure to abide by this requirement will result in automatic disqualification of the company representative at the discretion of the District.

Proposals should be based on duplication of the existing Plans of Benefits. Any deviations must be

clearly identified and explained. All proposals will be assumed to have been submitted without any deviations unless clearly noted.

All materials necessary to effectively communicate and administer the program shall be prepared and printed by the proposer at the proposer's own expense. These materials include, but are not limited to, master plan document, summary plan descriptions/schedule of benefits, claim forms, identification cards, check stock, and explanation of benefits.

If submitting manually, the appropriate enclosed proposal forms which include a Questionnaire, Rate Pages, Felony Conviction Notice, Non-Collusion Statement & Signature Sheet, Excel Spreadsheets, etc., must be completed and included with the response. An authorized official of the TPA/Carrier, PPO, and PBM with legal authority to bind the TPA/Carrier, PPO, and PBM must sign all proposal forms submitted. **FAILURE TO COMPLETE PROPOSAL FORMS MAY RESULT IN DISQUALIFICATION.**

The Edinburg Consolidated Independent School District accepts no financial responsibility for any costs incurred by any proposer in the course of responding to these specifications.

The Request for Proposals package will be available for download from our website at www.ecisd.us. Look for "Purchasing" inside the "Department" tab. Vendors WILL NOT be notified of additional information/addenda postings. It is the vendor's responsibility to view the ECISD's web page regularly, &/or prior to submitting a proposal response, to ensure that no addenda or additional information have been issued, or to obtain any addenda that may have been issued, for the solicitation. This proposal will also be available on the district's online platform IONWAVE. Vendor will need to register, if not already, prior to viewing/submitting an online submittal.

The proposal is to be based on the provided census as of February 2025 (MS-Excel format).

Effective date is January 1, 2026. The District will assist with coordination of the transfer of enrollment information including accumulator information in an electronic format; however, the successful vendor should be prepared with a contingency plan to effect a smooth transition within the time and with the information immediately available. The successful vendor should also be prepared to conduct education meetings regarding the new administration procedures and a full enrollment of all current participants on-site at multiple locations. Alternatively, the successful vendor must also be prepared to conduct a full re-enrollment electronically via a web-based application at no additional cost to the District.

Any estimated savings, performance or other guarantees included in any part of the proposal should be specific, quantifiable and should include a method for validation.

Enforceability - This Contract shall be interpreted, construed, and governed by the laws of the United States and the State of Texas and shall be enforceable in any court of competent jurisdiction in Hidalgo County, Texas.

Continuity of Coverage - All eligible individuals covered by the current plan are to receive immediate coverage under the new plan.

Advertising – Vendor will not advertise or publish that it has entered into an agreement with ECISD as an endorsement of services without prior written consent.

Gratuities - No gratuities in the form of entertainment, gifts or otherwise, shall be offered or given by

vendor or any representative of the vendor to any administrator, employee or anyone affiliated with the School District with a view toward securing a contract or securing favorable treatment with respect to a contract. Failure to comply with this requirement will cause the proposal to be rejected, or contract (if approved) to be void.

Enrollment - The following is the desired enrollment schedule for the selected TPA to follow:

September thru November 2025 - Enrollment of all ECISD Employees

Anticipated Tiimeline: The anticipated tentative timeline for the ECISD's RFP process is as follows:

DATE	DESCRIPTION
April 5, 2025	RFP Release Date
April 30, 2025	Vendor Questions Due
As they come in	Vendor Questions Answered
May 7, 2025	RFP Submission Deadline 3:00 P.M. (CST)
May 19, 2025	Inventory Submissions and Attachments
May 19-June 2025	Board Workshops • RFP Results Presentation by Administration • Vendor Presentations/Interviews
July 2025	Approval of Final Contract Award by ECISD Board of Trustees

Manual Submittals

For further information, Please submit questions in writing via email only to:

Dustin Garza, ECISD Insurance Manager
Dustin.garza@ecisd.us

Questions can also be submitted through the district's online portal.

The selection of a proposal for TPA/Carrier, PPO Services Network, and PBM Services will be made after careful evaluation of the proposals received. Each proposal will be evaluated for acceptability, with emphasis on the various factors enumerated in the table outlined below. Each factor is assigned a numerical score. The scores will be used to develop a list of potential providers with whom negotiations may be conducted.

Evaluations will be based on the following criteria, for which up to 100 points may be awarded. A total evaluation of 60 points will invalidate a proposal.

20 - Responses to Excel Workbooks
05 - Responses to RFP Questionnaire
05 - Experiences with School Districts
20 - Software Capabilities
10 - Experience with Direct Providers
10 - Network Providers
30 - Overall Cost

ECISD highly recommends responses be submitted electronically though this electronic bidding system as it helps expedite the bidding process and helps to alleviate errors. Manual responses will still be accepted as long as they are received by the close date and time listed on this bid event. **NO EMAILED OR FAXED RESPONSES WILL BE ACCEPTED FOR MANUAL SUBMITTALS.**

BOARD MEMBERS:
David Torres - President, Carmen Gonzalez - Vice-President, Letty Flores - Secretary, Luis Alamia - Member, Xavier Salinas - Member, Leticia "Letty" Garcia - Member, Dominga "Minga" Vela - Member, Dr. Mario H. Salinas- Superintendent of Schools.

Bid Attachments

1295 and Instructions.pdf View Online
Form 1295

CIQ Form.pdf View Online
Conflict of Interest (CIQ)

Hold Harmless.pdf View Online
Hold Harmless

W9 & Direct Deposit Form.pdf View Online
W9 & Direct Deposit Form

ATTACHMENT 1.xlsx View Online
Medical Claims to be Repriced

ATTACHMENT 2.xlsx View Online
Rx Claims to be Repriced

ATTACHMENT 3.xlsx View Online
Current ECISD utilized Medical Network Listing for RFP

ATTACHMENT 4.xlsx View Online
Current ECISD Pharmacy Network Utilized Listing for RFP

ATTACHMENT 5.pdf View Online
2025 BCBS Plan Document for RFP

ATTACHMENT 6.xlsx View Online
ECISD Census Feb 2025

ATTACHMENT 6b.xlsx View Online
ECISD Age Gender Band Census Feb 2025

ATTACHMENT 7.xlsx View Online
ECISD Large Claims Report HCC for RFP

ATTACHMENT 8.pdf View Online
Stop Loss Plan Summary RFP Redacted

ATTACHMENT 9.pdf View Online
Minimum Quality Assurance Standards

ATTACHMENT 10.pdf View Online
ECISD SOC

Requested Attachments

NOTE TO VENDOR

Please make sure that you label each upload with the designated tab. This will assist in the evaluation process and will be easier for the evaluators to locate.

TAB 1 - Introduction Letter

(Attachment required)

The introduction letter shall provide a summary of the information presented in the RFP; names and telephone/fax numbers of persons authorized to provide any clarification required. This cover letter shall also include the name of the person(s) authorized to conduct final contract negotiations.

TAB 2 - Company Information

(Attachment required)

Respondents must attach a complete set of qualifications on your company's ability to handle what is outlined in this RFP.

TAB 3 - Pricing

(Attachment required)

Detail Pricing of all costs associated with this RFP.

TAB 4 - District Required Forms

(Attachment required)

In this section please include your completed/signed:

- Conflict of Interest Questionnaire (CIQ)
- Certificate of Interested Parties (1295)
- Hold Harmless
- Substitute W-9 & Direct Deposit Authorization Form

TAB 5 - Questionnaires

(Attachment required)

Include in this section, if submitting RFP documents manually, your response to any and all questionnaires that you company will be submitting for.

TAB 6 - Response Workbooks

(Attachment required)

In this section upload the following attachments that pertain to your submittal:

- Attachment 1 - Medical Claims to be Repriced **(Must submit with TPA/PPO proposal)**
- Attachment 2 - Rx Claims to be Repriced **(Must submit with PBM or International Rx proposal)**
- Attachment 3 - Current ECISD utilized Medical Network Listing for RFP **(Must submit with PPO proposal)**
- Attachment 4 - Current ECISD Pharmacy Network Utilized Listing for RFP **(Must submit with PBM or International Rx proposal)**

Bid Attributes

1	**GENERAL CONDITIONS & RFP ASSUMPTIONS** Vendor has read and understood the General Conditions & RFP Assumptions. ☐ I have read and agree. *(Required: Check all that apply)*

2 FELONY CONVICTION NOTIFICATION

State of Texas Legislative Senate Bill No. 1, Section 44.034, Notification of Criminal History, Subsection (a), states "a person or business entity that enters into a contract with a school district must give advance notice to the district if the person or an owner or operator of the business entity has been convicted of a felony. The notice must include a general description of the conduct resulting in the conviction of a felony."

Subsection (b) states "a school district may terminate a contract with a person or business entity if the district determines that the person or the person or business entity failed to give notice as required by Subsection (a) or misrepresented the conduct resulting in the conviction. The district must compensate the person or business entity for services performed before the termination of the contract."

This Notice Is Not Required of a Publicly-Held Corporation

I, the undersigned agent for the firm named, certify that the information concerning notification of felony convictions has been reviewed by me and the following information furnished is true to the best of my knowledge.

☐ N/A Publicly-Traded Company

☐ Owner/Operator HAS NOT been convicted of a felony

☐ Owner/Operator HAS been convicted of a felony

(Required: Check all that apply)

3 FELONY CONVICTION DISCLOSURE

If the owner/operator has ever been convicted of a felony, please enter the details of the conviction in the field below to include the name(s) of felon(s) and a general description of the conduct resulting of the felony. Please type N/A if not applicable.

(Required: Maximum 4000 characters allowed)

4 PROPOSAL SPECIFICATION REQUIREMENTS

Is this proposal in conformance with the specifications?

☐ YES

☐ NO

(Required: Check all that apply)

5 **PROPOSAL SPECIFICATION REQUIREMENTS CONTINUED**

If the answer is no, offeror must identify and explain each exception taken, with reference to each page and paragraph to which the exception will apply.

It should be understood that if no exception is taken the offeror shall supply all items as specified. Failure to indicate any difference in products offered in this proposal may be deemed sufficient grounds for rejection of a vendor's proposal.

(Please attach additional page if needed under the Response Attachments tab)

(Required: Maximum 4000 characters allowed)

6 **AFFIDAVIT OF NON-COLLUSION**

By submission of this proposal or proposal, the bidder certifies that:

1. This bid or proposal has been independently arrived at without collusion with any other bidder or with any competitor;
2. This bid or proposal has not been knowingly disclosed and will not be knowingly disclosed, prior to the opening of proposals, or proposals for this project, to any other bidder, competitor or potential competitor;
3. No attempt has been or will be made to induce any other person, partnership or corporation to submit or not to submit a proposal or proposal;
4. The person signing this proposal or proposal certifies that he has fully informed himself regarding the accuracy of the statements contained in this certification, and under the penalties being applicable to the bidder as well as to the person signing in its behalf.

☐ I have read and agree.
(Required: Check all that apply)

7 **LINE ITEMS COMPLETION**

Vendor agrees that **ALL** lines & check boxes are filled in as needed even if it states as optional. If the question does not apply to you, you will need to enter in N/A**. FAILURE TO DO SO MAY DISQUALIFY YOUR SUBMITTAL AND BE CONSIDERED NON-RESPONSIVE.**

☐ I have read and agree.
(Required: Check all that apply)

8	**RFP ASSUMPTIONS**

- Self-Funded Plan, Carrier/Third Party Administrator (TPA), Preferred Provider Organization (PPO) Network, Pharmacy Benefit Management (PBM) Services, Transparent Modeling and or Pass-Through Modeling, International Rx Option and Stop Loss Coverage should submit proposals directly, net of commissions and no agent service fees. Proposal responses must include a complete disclosure of all revenues from all sources expected to be received from other providers related to this account.
- Proposals are desired for a primary term of one (3) year with the option to renew for five (5) additional one (1) year terms with a minimum of a 24-month rate guarantee (ASO services). However, Edinburg Consolidated ISD reserves the right to accept a guarantee of less than 24 months if it is in Edinburg Consolidated ISD's best interest.
- All pricing should be included in a separate tab, clearly marked and explained thoroughly.
- A proposed draft copy of an Administrative Service Agreement (ASA) must be submitted with your proposal response. An executed contract must be in place within 30 days of the awarding of the proposal.
- TPA/Carriers may include PPO Networks and PBM Services as part of their proposed services. All administration service fees must be included under the standard scheduled fee outline.
- All Submitters must submit completed attachments if applicable to services submitter is submitting for.
- Edinburg Consolidated ISD's Medical Plan is considered Grandfathered under the Affordable Care Act (ACA). Vendors are required to submit their proposals under this assumption.
- Pharmacy Benefit Management (PBM) services must be transparent. All Administrative Cost, Dispensing cost and all other associated cost must be clearly identified and outlined.
- Public Sector employers are not allowed, under current state law, to execute a document containing a Hold Harmless/Indemnification Clause causing the employer to be responsible for other parties' liability. Therefore, your documents should not contain any such clauses.
- Edinburg Consolidated ISD reserves the right to accept or reject all or any part of the proposal, waive minor technicalities, and award the proposal that best serves the interest of the District. The District also reserves the right to waive or dispense with any of the formalities contained herein. The Edinburg Consolidated ISD elective District Commissioners will make the final decision of agreement of award.

(Optional: Maximum 4000 characters allowed)

Bid Lines

1	**CLAIMS ADMINISTRATION QUESTIONNAIRE**

Item Attributes

1. DESCRIBE THE BUSINESS ENTITY SUBMITTING THE PROPOSAL

2. Name of TPA/PPO/PBM

(Optional: Maximum 1000 characters allowed)

3. Business Address

(Optional: Maximum 1000 characters allowed)

4. Mailing Address

(Optional: Maximum 1000 characters allowed)

5. Name of Account Executive/Representative assigned to the District

(Optional: Maximum 1000 characters allowed)

6. Telephone Number

(__ __ __) __ __ __ - __ __ __ __ ext:

(Optional)

7. Type of Business Entity

- ☐ Corporation
- ☐ General Partnership
- ☐ Sole Proprietorship
- ☐ Registered Limited Liability Partnership
- ☐ Limited Liability Company (Corporation)
- ☐ Limited Liability Company (General Partnership)

(Optional: Check all that apply)

8. Please provide jurisdiction for corporation or partnership charter.

(Optional: Maximum 1000 characters allowed)

9. Please provide date corporation or partnertship chartered.

(Optional: Maximum 1000 characters allowed)

10. Is the business entity licensed by the State of Texas as a Third Party Administrator?

☐ YES

☐ NO

(Optional: Check all that apply)

11. Will you agree to provide a resume for each key employee in your organization upon request?

☐ YES

☐ NO

(Optional: Check all that apply)

12. Has the business entity been a defendant in any lawsuit in any state or federal court during any of the preceding five (7) years?

☐ YES

☐ NO

(Optional: Check all that apply)

13. If yes, identify each lawsuit by party, case number, court, subject matter, and disposition.

(Optional: Maximum 4000 characters allowed)

14. Does the TPA/PPO/PBM have any claims filed against it which are unresolved and presently pending before any State of Texas Administrative agency?

☐ YES

☐ NO

(Optional: Check all that apply)

15. If yes, please provide a full description of the matter.

(Optional: Maximum 4000 characters allowed)

16. FINANCIAL INFORMATION

17. Has the business entity filed a voluntarty or involuntry petition in bankruptcy, obtained an order for relief, or received a discharge on any debt under the U.S. Bankruptcy laws during any of the preceding seven (7) years?

☐ YES

☐ NO

(Optional: Check all that apply)

18. If yes, provide the name of the court and the case number(s).

(Optional: Maximum 1000 characters allowed)

19. Has any owner, member, or partner of the business entity filed a petition in bankruptcy, obtained an order for relief, or received a discharge on any debt under the U.S. Bankruptcy laws during any of the preceding seven (7) years?

☐ YES

☐ NO

(Optional: Check all that apply)

20. If yes, provide the name of the court and the case number(s).

(Optional: Maximum 1000 characters allowed)

21. Audited financial statement for the preceding fiscal year included with response?

☐ YES

☐ NO

(Optional: Check all that apply)

22. DESCRIBE CLAIM ADMINISTRATION EXPERIENCE

23. Number of Clients

(Optional: Numbers only)

24. Number of Covered Employees

(Optional: Numbers only)

25. Other

(Optional: Maximum 1000 characters allowed)

26. PROVIDE FIVE (5) TEXAS CLIENT REFERENCES (PREFERABLY SCHOOL DISTRICTS)

Include the following:

- Name of Client
- Contact Person
- Telephone Number
- Number of Employees

27. Client Reference 1

(Optional: Maximum 1000 characters allowed)

28. Client Reference 2

(Optional: Maximum 1000 characters allowed)

29. Client Reference 3

(Optional: Maximum 1000 characters allowed)

30. Client Reference 4

(Optional: Maximum 1000 characters allowed)

31. Client Reference 5

(Optional: Maximum 1000 characters allowed)

32. QUALITY ASSURANCE PROCEDURES

Describe what quality assurance procedures you currently have in place to ensure accuracy of payments, eligibility, check draft security, appropriateness of treatment versus diagnosis, medical necessity, adherence to reasonable and customary allowances, coordination of benefits.

(Optional: Maximum 4000 characters allowed)

33. ADMINISTRATION CONTRACT

34. Will you allow the Edinburg CISD (District) to modify your standard Administration Contract?

☐ YES

☐ NO

(Optional: Check all that apply)

35. If no, please explain.

(Optional: Maximum 4000 characters allowed)

36. Will you agree to process 98% of all submitted claims within fifteen (15) business days at a minimum of 98% overall accuracy and/or other mutually agreed upon performance guarentees?

☐ YES

☐ NO

(Optional: Check all that apply)

37. Will you agree that a failure to uphold the standards in (33) and/or other mutually agreed upon performance guarantees may result in a penalty to be deducted from the admininstration fees?

☐ YES

☐ NO

(Optional: Check all that apply)

38. Will you allow the District to enter into Direct Provider Agreements?

☐ YES

☐ NO

(Optional: Check all that apply)

39. Will you agree to allow a third party to conduct an on-site claims audit without limitations?

☐ YES

☐ NO

(Optional: Check all that apply)

40. Will you agree to hold the District harmless if any of your firm is found to be negligent in the adminisntration of the Plan that result in IRS fines or penalties?

☐ YES

☐ NO

(Optional: Check all that apply)

41. Will you agree to serve as fiduciary with respect to the ECISD employee benefits plan and be subject to fiduciary responsibilities and obligations in your administration of the plan?

☐ YES

☐ NO

(Optional: Check all that apply)

42. Is a copy of an administrative services agreement (ASA) included with your response?

☐ YES

☐ NO

(Optional: Check all that apply)

43. Will you agree that ECISD will not be required to pay any additional fees, costs or expenses other than those expressly set forth in the proposal response?

☐ YES

☐ NO

(Optional: Check all that apply)

44. Will you certify that you will not receive any revenue or compensation from any other third party related to the services provided under the agreement except for the revenue and compensation expressly described in the proposal response form?

☐ YES

☐ NO

(Optional: Check all that apply)

45. Provide a list of all standard reports available to the District at no additional cost and the frequency of these reports.

46. CLAIM PAYMENT SERVICES

47. Location of office where actual claims will be paid?

(Optional: Maximum 1000 characters allowed)

48. Will a claims representative be assigned to this account?

☐ YES

☐ NO

(Optional: Check all that apply)

49. Will a claims representative be available for onsite claims handling on a scheduled basis in the first year?

☐ YES

☐ NO

(Optional: Check all that apply)

50. Will a toll free telephone number be available for checking status of claim?

☐ YES

☐ NO

(Optional: Check all that apply)

51. What is the average time on hold?

(Optional: Maximum 1000 characters allowed)

52. What is the abandonment rate?

(Optional: Maximum 1000 characters allowed)

53. Can School District's Employee Benefits Department speak directly to claim representative for questions related to repayment of claim?

☐ YES

☐ NO

(Optional: Check all that apply)

54. What is normal claim processing time?

(Optional: Maximum 1000 characters allowed)

55. Describe process of appeal for contested claim.

(Optional: Maximum 4000 characters allowed)

56. Do you screen for unbundling of provider charges?

☐ YES

☐ NO

(Optional: Check all that apply)

57. Do you pay for printing costs of checks and explanation of benefits?

☐ YES

☐ NO

(Optional: Check all that apply)

58. Is sample EOB and check included with your response?

☐ YES

☐ NO

(Optional: Check all that apply)

59. Please describe banking arrangements necessary to reimburse claims that are paid.

(Optional: Maximum 4000 characters allowed)

60. Describe basis and procedure for determining Reasonable and Customary.

(Optional: Maximum 4000 characters allowed)

61. Describe your firms audit requirements.

(Optional: Maximum 4000 characters allowed)

62. Describe procedure used for subrogation and recovery.

(Optional: Maximum 4000 characters allowed)

63. Is there a cost associated with this services?

(Optional: Maximum 4000 characters allowed)

64. OTHER AVAILABLE SERVICES (LIST ADDITIONAL COSTS, IF ANY)

65. Will Actuarial Services be available?

☐ YES

☐ NO

(Optional: Check all that apply)

66. Will your firm provide ACA reporting requirements under IRC sections 6005 & 6056?

☐ YES

☐ NO

(Optional: Check all that apply)

67. Is there a cost associated with that service?

☐ YES

☐ NO

(Optional: Check all that apply)

68. If yes, describe.

(Optional: Maximum 4000 characters allowed)

69. What additional steps will you take to ensure the District remains ACA compliant?

(Optional: Maximum 4000 characters allowed)

70. Describe experience in coordinating with Preferred Provider organizations (including re-pricing capabilities).

(Optional: Maximum 4000 characters allowed)

71. Describe your firms' approach negotiating with out-network providers.

(Optional: Maximum 4000 characters allowed)

72. Do you provide access to transplant network(s) through Admininstrative Services Agreement?

☐ YES

☐ NO

(Optional: Check all that apply)

73. Are On-Line Services available and included in the cost?

☐ YES

☐ NO

(Optional: Check all that apply)

74. Please describe (Claims Status, Enrollment, Provider Directory, Reports, Other)

(Optional: Maximum 4000 characters allowed)

75. Are enrollment meetings and monthly on site claims assistance included?

☐ YES

☐ NO

(Optional: Check all that apply)

76. Will all materials necessary to effectively communicate and administer the program be prepared and printed by proposer at proposer's expense?

(ex: ID Cards, Employee Benefit Book, Claim Forms, Scheduled of Benefits, EOB's, Certificates of Credible Coverage)

☐ YES

☐ NO

(Optional: Check all that apply)

77. Will employee ID cards, Employee Benefit Book and other related materials be mailed to the employee's home at the proposer's expense?

☐ YES

☐ NO

(Optional: Check all that apply)

78. Do you provide all required HIPPA notices?

☐ YES

☐ NO

(Optional: Check all that apply)

79. Are there additional costs associated with this service?

☐ YES

☐ NO

(Optional: Check all that apply)

80. Are your fees contingent upon bundle services?

☐ YES

☐ NO

(Optional: Check all that apply)

81. Do administrative fees include run-out claims processing upon termination?

☐ YES

☐ NO

(Optional: Check all that apply)

82. If not, how much do you charge for run-out processing? How long will your process those claims?

(Optional: Maximum 4000 characters allowed)

83. For what period of time are quoted rates guaranteed?

(Optional: Maximum 1000 characters allowed)

84. Is a longer rate guarantee available?

☐ YES

☐ NO

(Optional: Check all that apply)

85. Do admininstrative fees include run-out claims processing upon termination? If not, how much do you chage for run-out processing? How long will you process those claims?

(Optional: Maximum 4000 characters allowed)

86. Please state any variations to the RFP. Please explain.

(Optional: Maximum 4000 characters allowed)

2

PPO NETWORK SERVICES QUESTIONNAIRE

Item Attributes

1. DESCRIBE THE BUSINESS ENTITY SUBMITTING THE PROPOSAL

2. Name of Firm

(Optional: Maximum 1000 characters allowed)

3. Address

(Optional: Maximum 1000 characters allowed)

4. Contact Person

(Optional: Maximum 1000 characters allowed)

5. Telephone Number

(__ __ __) __ __ __ - __ __ __ __ ext:

(Optional)

6. Fax Number

(__ __ __) __ __ __ - __ __ __ __ ext:

(Optional)

7. Year Founded

(Optional: Maximum 1000 characters allowed)

8. DESCRIBE PPO NETWORK EXPERIENCE

9. Number of Clients

(Optional: Maximum 1000 characters allowed)

10. Number of Texas Clients

(Optional: Maximum 1000 characters allowed)

11. Number of Employees Covered

(Optional: Maximum 1000 characters allowed)

12. Number of Network Providers

(Optional: Maximum 1000 characters allowed)

13. Other

(Optional: Maximum 1000 characters allowed)

14. PROVIDE FIVE (5) TEXAS CLIENT REFERENCES (PREFERABLY SCHOOL DISTRICTS)

Include the following:

- Name of Client
- Contact Person
- Telephone Number
- Number of Employees

15. Client Reference 1

(Optional: Maximum 1000 characters allowed)

16. Client Reference 2

(Optional: Maximum 1000 characters allowed)

17. Client Reference 3

(Optional: Maximum 1000 characters allowed)

18. Client Reference 4

(Optional: Maximum 1000 characters allowed)

19. Client Reference 5

(Optional: Maximum 1000 characters allowed)

20. INSURANCE COVERAGE

The business entity must provide satisfactory evidence of existing insurance coverage in the amount of $1,000,000.00 for Errors and Omissions or other fiduciary liability. If the business entity is selected to provide services it must provide evidence that such coverage will e in effect for the duration of the agreement. Include copy of Insurance Certificate and upload under the "Response Attachment" tab.

21. PROVIDER NETWORK

22. Name of Network

(Optional: Maximum 1000 characters allowed)

23. Approximately how many lives are enrolled in the network?

24. Hidalgo County

(Optional: Maximum 1000 characters allowed)

25. Texas

(Optional: Maximum 1000 characters allowed)

26. United States

(Optional: Maximum 1000 characters allowed)

27. How long has the network been operational in Hidalgo County?

(Optional: Maximum 1000 characters allowed)

28. How many of each of the following medical providers participate in your Hidalgo County network? Do not count any physician more than once due to multiple locations or specialities.

29. Hospitals

(Optional: Maximum 1000 characters allowed)

30. Laboratory

(Optional: Maximum 1000 characters allowed)

31. Chiropractor

(Optional: Maximum 1000 characters allowed)

32. Internal Medicine

(Optional: Maximum 1000 characters allowed)

33. Pediatrics

(Optional: Maximum 1000 characters allowed)

34. OB/GYN

(Optional: Maximum 1000 characters allowed)

35. Allergist

(Optional: Maximum 1000 characters allowed)

36. Oncologist

(Optional: Maximum 1000 characters allowed)

37. Orthopedist

(Optional: Maximum 1000 characters allowed)

38. Urologist

(Optional: Maximum 1000 characters allowed)

39. Cardiologist

(Optional: Maximum 1000 characters allowed)

40. Dermatologist

(Optional: Maximum 1000 characters allowed)

41. Endrocrinologist

(Optional: Maximum 1000 characters allowed)

42. ENT

(Optional: Maximum 1000 characters allowed)

43. General Surgery

(Optional: Maximum 1000 characters allowed)

44. Neurology

(Optional: Maximum 1000 characters allowed)

45. Psychologist

(Optional: Maximum 1000 characters allowed)

46. Psychiatrist

(Optional: Maximum 1000 characters allowed)

47. Oral Surgeon

(Optional: Maximum 1000 characters allowed)

48. Other

(Optional: Maximum 1000 characters allowed)

49. TOTAL OF ALL THE ABOVE LOCATIONS

(Line items #29-48)

(Optional: Maximum 1000 characters allowed)

50. Describe network access outside of the Hidalgo County area for Specialty care not available in local area.

(Optional: Maximum 4000 characters allowed)

51. Other Texas Providers

(Optional: Maximum 4000 characters allowed)

52. Describe any special national networks that are utilized, such as National Centers of Excellence; specifically identify:

53. Each Center of Excellence facility with which you contract.

(Optional: Maximum 4000 characters allowed)

54. Nature of Illnesses//Conditions

(Optional: Maximum 4000 characters allowed)

55. Treatments/Services and providers covered by the contract.

(Optional: Maximum 4000 characters allowed)

56. If only selected providers are covered by the term of the contract.

(Optional: Maximum 4000 characters allowed)

57. How are cases selected for Centers of Excellence?

(Optional: Maximum 4000 characters allowed)

58. How do you communicate to members, their families and their providers the ability to take advantage of care at a Center of Excellence?

(Optional: Maximum 4000 characters allowed)

59. Does your firms Center of Excellence program include provisions of services, such as discounts at hotels or lodging to close relatives who are accompanying a member to the Center of Excellence?

(Optional: Maximum 4000 characters allowed)

60. Do you use an organ transplant network? If so, Describe the network.

(Optional: Maximum 4000 characters allowed)

61. Provide disruption analyses or % distruption expected. Supporting documentation for % disruption will be required.

(Optional: Maximum 4000 characters allowed)

62. PREFERRED PROVIDER SERVICES

63. Are the physicians in your network required to accept assignment of benefits?

☐ YES

☐ NO

(Optional: Check all that apply)

64. How do you prevent physicians in your network from balance billing?

(Optional: Maximum 4000 characters allowed)

65. Are you willing to provide current Provider Network information for providers currently under contract upon request?

☐ YES

☐ NO

(Optional: Check all that apply)

66. Describe procedure for notifying District of change in providers.

(Optional: Maximum 4000 characters allowed)

67. What criteria are used for selecting providers?

(Optional: Maximum 4000 characters allowed)

68. Describe provider discount structure and average savings generated by the provider discounts in this geographic area? How can your savings be documented?

(Optional: Maximum 4000 characters allowed)

69. Describe provider re-pricing procedures

(Optional: Maximum 4000 characters allowed)

70. Will you be willing to provide sample reports upon request?

☐ YES

☐ NO

(Optional: Check all that apply)

71. How often are Provider Directories updated?

(Optional: Maximum 1000 characters allowed)

72. Is Provider information available on-line?

☐ YES

☐ NO

(Optional: Check all that apply)

73. Describe claims cost management procedures.

(Optional: Maximum 4000 characters allowed)

74. Are out of network claims negotiated?

(Optional: Maximum 4000 characters allowed)

75. Do you have a re-pricing agreement for Out of Network Benefits?

☐ YES

☐ NO

(Optional: Check all that apply)

76. Please state any variations to the Request for Proposal Assumptions or other qualifications for your proposal.

(Optional: Maximum 4000 characters allowed)

77. For what period of time are quoted rates guarantee?

(Optional: Maximum 4000 characters allowed)

78. Is a longer rate guarantee available?

☐ YES

☐ NO

(Optional: Check all that apply)

3

PHARMACY BENEFIT MANAGEMENT QUESTIONNAIRE

Item Attributes

1. DESCRIBE ORGANIZATION SUBMITTING PROPOSAL

2. Name of Firm

(Optional: Maximum 1000 characters allowed)

3. Address

(Optional: Maximum 1000 characters allowed)

4. Contact Person

(Optional: Maximum 1000 characters allowed)

5. Telephone Number

(__ __ __) __ __ __ - __ __ __ __ ext:

(Optional)

6. Year Founded

(Optional: Maximum 1000 characters allowed)

7. DESCRIBE PRESCRIPTION DRUG EXPERIENCE

8. Number of Texas School District Clients

(Optional: Maximum 1000 characters allowed)

9. Name of Primary Network

(Optional: Maximum 1000 characters allowed)

10. Other

(Optional: Maximum 1000 characters allowed)

11. PROVIDE FIVE (5) TEXAS CLIENT REFERENCES (PREFERABLY SCHOOL DISTRICTS)

Include the following:

- Name of Client
- Contact Person
- Telephone Number
- Number of Employees

12. Client Reference 1

(Optional: Maximum 1000 characters allowed)

13. Client Reference 2

(Optional: Maximum 1000 characters allowed)

14. Client Reference 3

(Optional: Maximum 1000 characters allowed)

15. Client Reference 4

(Optional: Maximum 1000 characters allowed)

16. Client Reference 5

(Optional: Maximum 1000 characters allowed)

17. Describe Pharmacy Network

18. Will you be willing to provide list of pharmacists currently in pharmacy network in Hidalgo County and Cameron County upon request?

☐ YES

☐ NO

(Optional: Check all that apply)

19. Describe relationship with pharmacists including degree of automation and reimbursement procedures.

(Optional: Maximum 4000 characters allowed)

20. The District is soliciting Transparent Modeling only, is your proposal transparent?

☐ YES

☐ NO

(Optional: Check all that apply)

21. SERVICES

22. Will your proposal provide real time software free of charge?

☐ YES

☐ NO

(Optional: Check all that apply)

23. Will you agree that ECISD will not be required to pay any additional fees, costs, or expenses other than those expressly set forth in the proposal response?

☐ YES

☐ NO

(Optional: Check all that apply)

24. Will your standard monthly reports contain all dispensing data? (NDC, drug name, strength, days' supply, ingredient cost, AWP, etc.).

☐ YES

☐ NO

(Optional: Check all that apply)

25. Is there a copy attached?

☐ YES

☐ NO

(Optional: Check all that apply)

26. Will you provide a copy of the current Maximum Allowable Cost (MAC) pricing?

☐ YES

☐ NO

(Optional: Check all that apply)

27. What is the percentage of the MAC expressed as a percentage of the available generics?

(Optional: Maximum 1000 characters allowed)

28. Will there be a price differential (spread) between the amounts paid to the pharmacy providers and the amount billed to the District?

☐ YES

☐ NO

(Optional: Check all that apply)

29. Will your agreement allow for third party audits of all rights and obligations under the agreement?

☐ YES

☐ NO

(Optional: Check all that apply)

30. Will the District retain the right to select the auditor at its discretion?

☐ YES

☐ NO

(Optional: Check all that apply)

31. Has the business entity been a defendant in any lawsuits in any state or federal court during any of the preceding seven (7) years?

☐ YES

☐ NO

(Optional: Check all that apply)

32. If yes, identify each lawsuit by party, case number, court, subject matter, and disposition.

(Optional: Maximum 4000 characters allowed)

33. Does the TPA/Carrier have any claims filed against it which are unresolved and presently pending before any State of Texas Administrative agency?

☐ YES

☐ NO

(Optional: Check all that apply)

34. If yes, please provide a full description of the matter.

(Optional: Maximum 4000 characters allowed)

35. PRESCRIPTON DRUG COSTS

Attach complete fee schedule including dispensing and AWP drug cost per 30-day supply. Include adminstration fees, or any other fees associated with this proposal.

36. For what period of time are proposed rates guaranteed?

(Optional: Maximum 1000 characters allowed)

37. Is there a MAC pricing guarantee?

☐ YES

☐ NO

(Optional: Check all that apply)

38. Do all pharmaceuticals follow the current Food and Drug Administration (FDA) regulations?

☐ YES

☐ NO

(Optional: Check all that apply)

39. Discount, Rebates, Volume Pricing

Will you agree and certify that you will pass through all discounts, rebates, volume pricing and any other prescription-related payments from pharmaceutical companies and other beneficial pricing to ECISD as it relates to all prescription drugs administered through the plan?

☐ YES

☐ NO

(Optional: Check all that apply)

40. Are there any administration fees?

☐ YES

☐ NO

(Optional: Check all that apply)

41. Will you certify that you will not recieve any compensation or revenue from any other third party related to the services provided under the agreement without the written consent of the Board of Trustees?

☐ YES

☐ NO

(Optional: Check all that apply)

42. Will you provide member ID cards free of charge?

☐ YES

☐ NO

(Optional: Check all that apply)

43. If yes, how long will this process take?

(Optional: Maximum 1000 characters allowed)

44. OTHER

45. Does your proposal include 100% prescription rebates with no sharing?

☐ YES

☐ NO

(Optional: Check all that apply)

46. Please explain rebate program.

(Optional: Maximum 4000 characters allowed)

47. Please state any variations to the Request for Proposal Assumptions or other qualifications for your proposal.

(Optional: Maximum 4000 characters allowed)

48. FINANCIAL INFORMATION

49. Has the business entity filed a voluntary or involuntary petition in bankruptcy, obtained an order for relief, or received a discharge on any debt under the U.S. Bankruptcy laws during any of the preceding seven (7) years?

☐ YES

☐ NO

(Optional: Check all that apply)

50. If yes, provide the name of the court and the case number(s).

(Optional: Maximum 4000 characters allowed)

51. Has any owner, member, or partner of the business entity filed a petition in bankruptcy, obtained an order for relief, or received a discharge on any debt under the U.S. Bankruptcy laws during any of the preceding seven (7) years?

☐ YES

☐ NO

(Optional: Check all that apply)

52. If yes, provide the name of the court and the case number(s).

(Optional: Maximum 4000 characters allowed)

53. Audited financial statement for the preceding fiscal year included with response?

If yes, please include attachment under "Response Attachment"

☐ YES

☐ NO

(Optional: Check all that apply)

4

INTERNATIONAL MAIL ORDER Rx BENEFIT MANAGEMENT QUESTIONNAIRE

Item Attributes

1. DESCRIBE ORGANIZATION SUBMITTING PROPOSAL

2. Name of Firm

(Optional: Maximum 1000 characters allowed)

3. Address

(Optional: Maximum 1000 characters allowed)

4. Contact Person

(Optional: Maximum 1000 characters allowed)

5. Telephone Number

(__ __ __) __ __ __ - __ __ __ __ ext:

(Optional)

6. Year Founded

(Optional: Maximum 1000 characters allowed)

7. DESCRIBE PRESCRIPTION DRUG EXPERIENCE:

8. Number of Texas School District Clients

(Optional: Maximum 1000 characters allowed)

9. Name of Primary Network (if applicable)

(Optional: Maximum 1000 characters allowed)

10. Other

(Optional: Maximum 1000 characters allowed)

11. PROVIDE FIVE (5) TEXAS CLIENT REFERENCES (PREFERABLY SCHOOL DISTRICTS)

Include the following:

- Name of Client
- Contact Person
- Telephone Number
- Number of Employees

12. Client Reference 1

(Optional: Maximum 1000 characters allowed)

13. Client Reference 2

(Optional: Maximum 1000 characters allowed)

14. Client Reference 3

(Optional: Maximum 1000 characters allowed)

15. Client Reference 4

(Optional: Maximum 1000 characters allowed)

16. Client Reference 5

(Optional: Maximum 1000 characters allowed)

17. DESCRIBE PHARMACY NETWORK

18. Will you be providing a list of offices and facilities that would provide services under this contract?

☐ YES

☐ NO

(Optional: Check all that apply)

19. Will you be providing a list of countries with participating pharmacies?

☐ YES

☐ NO

(Optional: Check all that apply)

20. Describe relationship with pharmacists including degree of automation and reimbursement procedures.

(Optional: Maximum 4000 characters allowed)

21. The District is solicitiing Transparent Modeling. Is your proposal transparent?

☐ YES

☐ NO

(Optional: Check all that apply)

22. SERVICES

23. Will you agree that ECISD will not be required to pay any additional fees, cost, or expreses other than those expressly set forth in the proposal response?

☐ YES

☐ NO

(Optional: Check all that apply)

24. Will your Standard monthly reports contain all dispensing data? (NDC, Drug name, strength, days' supply, ingredient cost, AWP, etc.)

☐ YES

☐ NO

(Optional: Check all that apply)

25. Is there a copy of that report attached?

☐ YES

☐ NO

(Optional: Check all that apply)

26. Will there be a price differential (spread) between the amounts paid to the pharmaceutical providers and the amount billed to the District?

☐ YES

☐ NO

(Optional: Check all that apply)

27. Will your Agreement allow for third party audits of all rights and obligations under the agreement?

☐ YES

☐ NO

(Optional: Check all that apply)

28. Will the District retain the right to select the auditor at its discretion?

☐ YES

☐ NO

(Optional: Check all that apply)

29. Has the business entity been a defendant in any lawsuit in any state or federal court during any of the proceding seven (7) years?

☐ YES

☐ NO

(Optional: Check all that apply)

30. If yes, identify each lawsuit by party, case number, court, subject matter, and disposition.

(Optional: Maximum 4000 characters allowed)

31. Vendor will provide pharmaceuticals that meet the quality assurance standards. The District's preferred quality assurance standards are outlined in: Attachment 9 Minimum Quality Assurance Standards

32. Work with the District to develop a revolving formulary of various pharmaceuticals that provide the most competitive pricing for members.

33. PRESCRIPTON DRUG COSTS

Ensure that the proposed pharmaceutical price in U.S. dollars shall only be increased or decreased to reflect the following:

- Price increases or decreases by the manufacturer and/or distributor for the cost of the pharmaceutical(s)
- Please provide a sample of the monthly billing report that ECISD will obtain for payment.
- Please provide a full fee schedule for services.

34. In case of price increase required due to market shortage or market change will you notify the District?

The pricing offered through this RFP must remain firm for the term of the Contract. Price decreases and/or discount percentage in favor of the District are acceptable at any time throughout the term of the contract.

☐ YES

☐ NO

(Optional: Check all that apply)

5

STOP LOSS INSURANCE QUESTIONNAIRE

Item Attributes

1. DESCRIBE ORGANIZATION SUBMITTING PROPOSAL

2. Insurance Company Name

(Optional: Maximum 1000 characters allowed)

3. Address

(Optional: Maximum 1000 characters allowed)

4. Contact Person

(Optional: Maximum 1000 characters allowed)

5. Telephone Number

(__ __ __) __ __ __ - __ __ __ __ ext:

(Optional)

6. Fax Number

(__ __ __) __ __ __ - __ __ __ __ ext:

(Optional)

7. Year Founded

Insurance Company

(Optional: Maximum 1000 characters allowed)

8. Managing Underwriter's Name

(Optional: Maximum 1000 characters allowed)

9. Year Founded

Managing Underwriter

(Optional: Maximum 1000 characters allowed)

10. Number of Years for Representing Insurance Company

(Optional: Maximum 1000 characters allowed)

11. What percentage of overall business is Health related?

(Optional: Maximum 1000 characters allowed)

12. DESCRIBE FINANCIAL STABILITY OF INSURANCE COMPANY

13. A.M. Best

Current Rating

(Optional: Maximum 1000 characters allowed)

14. A.M. Best

Prior Year Rating

(Optional: Maximum 1000 characters allowed)

15. A.M. Best

Prior 2 Years Rating

(Optional: Maximum 1000 characters allowed)

16. Moody's Standard & Poors

Current Rating

(Optional: Maximum 1000 characters allowed)

17. Moody's Standard & Poors

Prior Year Rating

(Optional: Maximum 1000 characters allowed)

18. Moody's Standard & Poors

Prior 2 Years Rating

(Optional: Maximum 1000 characters allowed)

19. Duff & Phelps

Current Rating

(Optional: Maximum 1000 characters allowed)

20. Duff & Phelps

Prior Year Rating

(Optional: Maximum 1000 characters allowed)

21. Duff & Phelps

Prior 2 Years Rating

(Optional: Maximum 1000 characters allowed)

22. Is Insurance Company authorized to do business in Texas?

☐ YES

☐ NO

(Optional: Check all that apply)

23. PROVIDE FIVE (5) TEXAS CLIENT REFERENCES (PREFERABLY SCHOOL DISTRICTS)

Include the following:

- Name of Client
- Contact Person
- Telephone Number
- Number of Employees

24. Client Reference 1

(Optional: Maximum 1000 characters allowed)

25. Client Reference 2

(Optional: Maximum 1000 characters allowed)

26. Client Reference 3

(Optional: Maximum 1000 characters allowed)

27. Client Reference 4

(Optional: Maximum 1000 characters allowed)

28. Client Reference 5

(Optional: Maximum 1000 characters allowed)

29. DESCRIBE THE BUSINESS ENTITY SUBMITTING THE PROPOSAL

30. Name of Business Entity

(Optional: Maximum 1000 characters allowed)

31. Current Business Address

(Optional: Maximum 1000 characters allowed)

32. Mailing Address

(Optional: Maximum 1000 characters allowed)

33. Telephone Number

(__ __ __) __ __ __ - __ __ __ __ ext:

(Optional)

34. Contact Person

(Optional: Maximum 1000 characters allowed)

35. Type of Business Entity

☐ Corporation

☐ General Partnership

☐ Registered Limited Liability Partnership

☐ Limited Liability Company

☐ Sole Proprietorship

(Optional: Check all that apply)

36. Has the business entity been a defendant in any lawsuit in any state or federal court during the preceding 7 years?

☐ YES

☐ NO

(Optional: Check all that apply)

37. If yes, identify each lawsuit by party, case number, court, subject matter, and disposition.

(Optional: Maximum 1000 characters allowed)

38. Does the business entity have any claims filed against it which are unresolved and presently pending before any State of Texas Administrative agency?

☐ YES

☐ NO

(Optional: Check all that apply)

39. If yes, please provide a full description of the matter.

(Optional: Maximum 4000 characters allowed)

40. FINANCIAL INFORMATION

41. Has the business entity filed a voluntary or involuntary petition in bankruptcy, obtained an order for relief, or received a discharge on any debt under the U.S. Bankruptcy laws during the preceding 7 years?

☐ YES

☐ NO

(Optional: Check all that apply)

42. If yes, provide the name of the court and the case number(s).

(Optional: Maximum 1000 characters allowed)

43. Has any owner, member, or partner of the business entity filed a petition in bankruptcy, obtained an order for relief, or received a discharge on any debt under the U.S. Bankruptcy laws furing the preceding 7 years?

☐ YES

☐ NO

(Optional: Check all that apply)

44. If yes, provide the name of the individual(s), name of court, and the case number(s).

(Optional: Maximum 4000 characters allowed)

45. If Managing General Underwriter (MGU), do you handle claims in-house?

☐ YES

☐ NO

(Optional: Check all that apply)

46. If not, who handles them?

(Optional: Maximum 1000 characters allowed)

47. If Managing General Underwriter (MGU), are there additional Insurance Carriers accepting layers of risk?

☐ YES

☐ NO

(Optional: Check all that apply)

48. Please disclose the Names, Addresses, and Phone Numbers of those carriers and the percentage of risk taken.

(Optional: Maximum 4000 characters allowed)

49. Describe Individual Stop Loss (ISL) and Aggregate Stop Loss (ASL).

50. Where will claims be paid?

(Optional: Maximum 4000 characters allowed)

51. What is the definition of "paid claim" to be eligible for reimbursement?

(Optional: Maximum 4000 characters allowed)

52. What is normal processing time for Individual Stop Loss (ISL) claim?

(Optional: Maximum 4000 characters allowed)

53. What is normal processing time for Aggretate Stop Loss (ASL) claim?

(Optional: Maximum 4000 characters allowed)

54. What are eligible expenses related to investigation of claim?

(e.g. hospital audit, medical records, etc.)

(Optional: Maximum 4000 characters allowed)

55. If the District has negotiated discounts with providers, will these discounts be accepted in lieu of doing a hospital audit?

☐ YES

☐ NO

(Optional: Check all that apply)

56. Describe documentation needed for Individual Stop Loss (ISL) claim reimbursement?

(Optional: Maximum 4000 characters allowed)

57. What is the maximum Specific & Aggregate payout limit?

(Optional: Maximum 4000 characters allowed)

58. What is the maximum time you allow for submission of Stop Loss payments by a TPA?

(Optional: Maximum 4000 characters allowed)

59. DESCRIBE RENEWAL UNDERWRITING

60. Will any claimants be excluded or assigned a higher deductible at time of renewal?

☐ YES

☐ NO

(Optional: Check all that apply)

61. If so, please describe.

(Optional: Maximum 4000 characters allowed)

62. Will renewal rates be provided to District 90 days prior to renewal date?

☐ YES

☐ NO

(Optional: Check all that apply)

63. What trend factors have you used in your proposal?

64. Health Utilization

(Optional: Maximum 1000 characters allowed)

65. Health Inflation

(Optional: Maximum 1000 characters allowed)

66. Health Total

(Optional: Maximum 1000 characters allowed)

67. RX Utilization

(Optional: Maximum 1000 characters allowed)

68. RX Inflation

(Optional: Maximum 1000 characters allowed)

69. RX Total

(Optional: Maximum 1000 characters allowed)

70. How do you calculate trend adjustments - mid-point or effective date?

(Optional: Maximum 4000 characters allowed)

71. Does your stop loss insurance contract have any exclusions or limitations that are more restrictive than those used in the District's booklet?

☐ YES

☐ NO

(Optional: Check all that apply)

72. If so, please describe.

(Optional: Maximum 4000 characters allowed)

73. Are the active-at-work and disables dependent provisions waived for the effective date of the contract?

☐ YES

☐ NO

(Optional: Check all that apply)

74. Describe transplant coverage procedures (including network).

(Optional: Maximum 4000 characters allowed)

75. Please state any variations to the RFP Assumptions or other qualifications for your quote.

(Optional: Maximum 4000 characters allowed)

76. How recent must claims experience be in order to provide final terms?

(Optional: Maximum 4000 characters allowed)

77. For what period of time are quoted rates guarantee?

(Optional: Maximum 4000 characters allowed)

78. Is a longer rate guarantee available?

☐ YES

☐ NO

(Optional: Check all that apply)

79. If so, please describe.

(Optional: Maximum 4000 characters allowed)

80. Do quoted rates include commission?

☐ YES

☐ NO

(Optional: Check all that apply)

81. If so, please describe.

(Optional: Maximum 4000 characters allowed)

Supplier Information

Company Name:

Contact Name:

Address:

Phone:

Fax:

Email:

Supplier Notes

By submitting your response, you certify that you are authorized to represent and bind your company.

Print Name

Signature