REQUEST FOR PROPOSALS FOR

Providing Medical, Prescription, Dental, Vision and Cobra
Benefits, and a Stop Loss Insurance Plan

ISSUING OFFICE

Pennsylvania Turnpike Commission

Human Resources Department

RFP NUMBER

07-113-3531

DATE OF ISSUANCE

May 2, 2007
REQUEST FOR PROPOSALS FOR

Providing Medical, Prescription, Dental, Vision and Cobra
Benefits, and a Stop Loss Insurance Plan

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COPIES OF THE APPENDICES WILL BE PROVIDED BY WRITTEN REQUEST ONLY.

SEND REQUESTS SPECIFYING APPENDICES NEEDED TO PATRICK BURNS, AS REFERENCED IN PART I-2, INCLUDING YOUR COMPANY NAME, CONTACT PERSON, AND EMAIL ADDRESS.
PART I

GENERAL INFORMATION FOR PROPOSERS

I-1. **Purpose.** This request for proposals (RFP) provides interested Proposers with sufficient information to enable them to prepare and submit proposals for consideration by the Pennsylvania Turnpike Commission (Commission) to satisfy a need for Health Care Benefits and Services.

I-2. **Issuing Office.** This RFP is issued for the Commission by the Pennsylvania Turnpike Commission, PO Box 67676, Human Resources, Harrisburg, PA 17106, (717) 939-9551. The contact person for this RFP is Patrick Burns in the Human Resources Department. He can be reached by mail at the address above, by email at pburns@paturnpike.com by phone at (717) 939-9551, ext. 4142, or by fax at (717) 986-8760. The Issuing Office is the sole point of contact in the Commission for this RFP.

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

I-4. **Problem Statement.** Provide Health Care Benefits and Services for the Commission within the guidelines explained in this RFP.

I-5. **Type of Contract.** It is proposed that if a contract is entered into as a result of this RFP, it will be a variable cost contract based on the line of coverage. The Commission may in its sole discretion undertake negotiations with Proposers whose proposals as to price and other factors show them to be qualified, responsible, and capable of performing the work.

I-6. **Rejection of Proposals.** The Commission reserves the right to reject any and all proposals received as a result of this request, or to negotiate separately with competing Proposers.

I-7. **Subcontracting.** Any use of subcontractors by a Proposer must be identified in the proposal. During the contract period use of any subcontractors by the selected Proposer, that were not previously identified in the proposal, must be approved in advance in writing by the Commission.

A firm that responds to this solicitation as a prime may not be included as a designated subcontractor to another firm that responds to the same solicitation. **Multiple responses under any of the foregoing situations may cause the rejection of all responses of the firm or firms involved.** This does not preclude a firm from being set forth as a designated subcontractor to more than one prime contractor responding to the project advertisement.

I-8. **Incurring Costs.** The Commission is not liable for any costs the Proposer incurs in preparation and submission of its proposal, in participating in the RFP process or in anticipation of award of contract.

I-9. **Mandatory Pre-proposal Conference.** A mandatory pre-proposal conference will be held on Monday, May 14, 2007 at 2:00pm local time at the Pennsylvania Turnpike Commission Administration Building located at 700 S. Eisenhower Blvd, Middletown, PA 17057. The purpose of this conference is to clarify any points in the RFP which may not have been clearly understood. Questions should be
forwarded to the Issuing Office prior to the meeting to ensure sufficient analysis can be made before an answer is supplied. Written questions should be submitted to Patrick Burns at the Issuing Office address indicated above to be received no later than Thursday, May 10, 2007 at 12:00 noon local time. In view of the limited facilities available for the conference, it is requested representation be limited to three individuals per Proposer. The pre-proposal conference is for information only. Answers furnished during the conference will not be official until verified, in writing, by the Issuing Office. All questions and written answers will be issued as an addendum to and become part of this RFP.

**FAILURE TO BE REPRESENTED AND SIGNED IN AT THIS MANDATORY PRE-PROPOSAL CONFERENCE WILL BE CAUSE FOR REJECTION OF PROPOSAL.**

I-10. **Addenda to the RFP.** If it becomes necessary to revise any part of this RFP before the proposal response date, addenda will be posted to the Commission’s website under the original RFP document.

The Commission may revise a published advertisement. If the Commission revises a published advertisement less than ten days before the RFP due date, the due date will be extended to maintain the minimum ten-day advertisement duration if the revision alters the project scope or selection criteria. Firms are responsible to monitor advertisements/addenda to assure the submitted proposal complies with any changes in the published advertisement.

I-11. **Response.** To be considered, proposals must be delivered to the Pennsylvania Turnpike Commission’s Contract Administration Department, Attention Fran Furjanic, no later than 12:00 noon local time on June 15, 2007. The Pennsylvania Turnpike Commission is located at 700 South Eisenhower Blvd., Middletown, PA 17057. Please note that use of U.S. Mail delivery does not guarantee delivery to this address by the above-listed time for submission. Proposers mailing proposals should allow sufficient delivery time to ensure timely receipt of their proposals. If the Commission office location to which proposals are to be delivered is closed on the proposal response date due to inclement weather, natural disaster, or any other cause, the deadline for submission shall be automatically extended until the next Commission business day on which the office is open. Unless the Proposers are otherwise notified by the Commission, the time for submission of proposals shall remain the same.

I-12. **Proposals.** To be considered, Proposers should submit a complete response to this RFP, using the format provided in Part II. Each proposal should be submitted in 8 copies to the Contract Administration Department. No other distribution of proposals will be made by the Proposer. Each proposal page should be numbered for ease of reference. Proposals must be signed by an official authorized to bind the Proposer to its provisions and include the Proposer’s Federal Identification Number. For this RFP, the proposal must remain valid from the submission to the Effective Date of March 1, 2008. Moreover, the contents of the proposal of the selected Proposer will become contractual obligations if a contract is entered into.

Each and every Proposer submitting a proposal specifically waives any right to withdraw or modify it, except as hereinafter provided. Proposals may be withdrawn by written or telefax notice received at the Commission’s address for proposal delivery prior to the exact hour and date specified for proposal receipt. However, if the Proposer chooses to attempt to provide such written notice by telefax transmission, the Commission shall not be responsible or liable for errors in telefax transmission. A proposal may also be withdrawn in person by a Proposer or its authorized representative, provided its identity is made known and it signs a receipt for the proposal, but only if the withdrawal is made prior to the exact hour and date set for proposal receipt. A proposal may only be modified by the submission of
a new sealed proposal or submission of a sealed modification which complies with the requirements of this RFP.

I-13. Economy of Preparation. Proposals should be prepared simply and economically, providing a straightforward, concise description of the Proposer’s ability to meet the requirements of the RFP.

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

I-15. Best and Final Offers. The Issuing Office reserves the right to conduct discussions with Proposers for the purpose of obtaining “best and final offers.” To obtain best and final offers from Proposers, the Issuing Office may do one or more of the following: a) enter into pre-selection negotiations; b) schedule oral presentations; and c) request revised proposals. The Issuing Office will limit any discussions to responsible Proposers whose proposals the Issuing Office has determined to be reasonably susceptible of being selected for award.

I-16. Prime Proposer Responsibilities. The selected Proposer will be required to assume responsibility for all services offered in its proposal whether or not it produces them. Further, the Commission will consider the selected Proposer to be the sole point of contact with regard to contractual matters.

I-17. Proposal Contents. Proposals will be held in confidence and will not be revealed or discussed with competitors, unless disclosure is required to be made (i) under the provisions of any Commonwealth or United States statute or regulation; or (ii) by rule or order of any court of competent jurisdiction. If a contract is executed, however, the successful proposal submitted in response to this RFP shall be subject to disclosure. All material submitted with the proposal becomes the property of the Pennsylvania Turnpike Commission and may be returned only at the Commission’s option. Proposals submitted to the Commission may be reviewed and evaluated by any person other than competing Proposers at the discretion of the Commission. The Commission has the right to use any or all ideas presented in any proposal. Selection or rejection of the proposal does not affect this right.

I-18. Debriefing Conferences. Proposers whose proposals are not selected will be notified of the name of the selected Proposer and given the opportunity to be debriefed, at the Proposer’s request. The Issuing Office will schedule the time and location of the debriefing. The Proposer will not be compared with other Proposers, other than the position of its proposal in relation to all other proposals for each criterion for selection.

I-19. News Releases. News releases pertaining to this project will not be made without prior Commission approval, and then only in coordination with the Issuing Office.

I-20. Commission Participation. Unless specifically noted in this section, Proposers must provide all services to complete the identified work. Human Resources will provide an administrative contact/liaison for oversight of billing and coordination of benefits.

I-21. Cost Submittal. The cost submittal shall be placed in a separately sealed envelope within the sealed proposal and kept separate from the technical submittal. Failure to meet this requirement may result in disqualification of the proposal.
I-22. **Term of Contract.** The term of the contract will commence on the Effective Date (as defined below) and will end three years from the Effective Date with an option of two one-year plan extensions. The Commission shall fix the Effective Date after the contract has been fully executed by the Contractor and by the Commission and all approvals required by Commission contracting procedures have been obtained.

I-23. **Proposer’s Representations and Authorizations.** Each Proposer by submitting its proposal understands, represents, and acknowledges that:

a. All information provided by, and representations made by, the Proposer in the proposal are material and important and will be relied upon by the Issuing Office in awarding the contract(s). Any misstatement, omission or misrepresentation shall be treated as fraudulent concealment from the Issuing Office of the true facts relating to the submission of this proposal. A misrepresentation shall be punishable under 18 Pa. C.S. 4904.

b. The price(s) and amount of this proposal have been arrived at independently and without consultation, communication or agreement with any other Proposer or potential Proposer.

c. Neither the price(s) nor the amount of the proposal, and neither the approximate price(s) nor the approximate amount of this proposal, have been disclosed to any other firm or person who is a Proposer or potential Proposer, and they will not be disclosed on or before the proposal submission deadline specified in the cover letter to this RFP.

d. No attempt has been made or will be made to induce any firm or person to refrain from submitting a proposal on this contract, or to submit a proposal higher than this proposal, or to submit any intentionally high or noncompetitive proposal or other form of complementary proposal.

e. The proposal is made in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary or other noncompetitive proposal.

f. To the best knowledge of the person signing the proposal for the Proposer, the Proposer, its affiliates, subsidiaries, officers, directors, and employees are not currently under investigation by any governmental agency and have not in the last four (4) years been convicted or found liable for any act prohibited by State or Federal law in any jurisdiction, involving conspiracy or collusion with respect to bidding or proposing on any public contract, except as disclosed by the Proposer in its proposal.

g. To the best of the knowledge of the person signing the proposal for the Proposer and except as otherwise disclosed by the Proposer in its proposal, the Proposer has no outstanding, delinquent obligations to the Commonwealth including, but not limited to, any state tax liability not being contested on appeal or other obligation of the Proposer that is owed to the Commonwealth.

h. The Proposer is not currently under suspension or debarment by the Commonwealth, or any other state, or the federal government, and if the Proposer cannot certify, then it shall
submit along with the proposal a written explanation of why such certification cannot be made.

i. The Proposer has not, under separate contract with the Issuing Office, made any recommendations to the Issuing Office concerning the need for the services described in the proposal or the specifications for the services described in the proposal.

j. Each Proposer, by submitting its proposal, authorizes all Commonwealth agencies to release to the Commission information related to liabilities to the Commonwealth including, but not limited to, taxes, unemployment compensation, and workers’ compensation liabilities.
PART II

INFORMATION REQUIRED FROM PROPOSERS

Proposals must be submitted in the format, including heading descriptions, outlined below. To be considered, the proposal must respond to all requirements in this part of the RFP. Any other information thought to be relevant, but not applicable to the enumerated categories, should be provided as an appendix to the proposal. Each proposal shall consist of two (2) separately sealed submittals. The submittals are as follows: (i) Technical Submittal, in response to Sections II-1 through II-[7] hereof; (ii) Cost Submittal, in response to Section II-[8] hereof.

The Commission reserves the right to request additional information which, in the Commission’s opinion, is necessary to assure that the Proposer’s competence, number of qualified employees, business organization, and financial resources are adequate to perform according to the RFP.

The Commission may make such investigations as deemed necessary to determine the ability of the Proposer to perform the work, and the Proposer shall furnish to the Issuing Office all such information and data for this purpose as requested by the Commission. The Commission reserves the right to reject any proposal if the evidence submitted by, or investigation of, such Proposer fails to satisfy the Commission that such Proposer is properly qualified to carry out the obligations of the agreement and to complete the work specified.

II-1. Statement of the Problem. State in succinct terms your understanding of the problem presented or the service required by this RFP.

II-2. Management Summary. Include a narrative description of the proposed effort and a list of the items to be delivered or services to be provided.

II-3. Work Plan. Describe in narrative form your technical plan for accomplishing the work. Use the task descriptions in Part IV of this RFP as your reference point. Modifications of the task descriptions are permitted; however, reasons for changes should be fully explained. Indicate the number of person hours allocated to each task. If more than one approach is apparent, comment on why you chose this approach.

II-4. Prior Experience. Include experience in administration of benefit programs and funding arrangements. Experience shown should be work done by individuals who will be assigned to this project as well as that of your company. Studies or projects referred to should be identified and the name of the customer shown, including the name, address, and telephone number of the responsible official of the customer, company, or agency who may be contacted. Please include the number of employees in the customer’s plan and their Account Manager.

II-5. Personnel. Include the number, and names where practicable, of executive and professional personnel, analysts, auditors, researchers, programmers, consultants, etc., who will be engaged in the work. Show where these personnel will be physically located during the time they are engaged in the work. Include through a resume or similar document education and experience in administration of benefit programs and funding arrangements, with specific experience in administering the program in a public sector and predominantly union environment. Indicate the responsibilities each will have in this project and how long each has been with your company. Identify subcontractors you intend to use and the services they will perform.
II-6. Training. If appropriate, indicate recommended training of Commission personnel. Include the personnel to be trained, the number to be trained, duration of the program, place of training, curricula, training materials to be used, number and frequency of sessions, and number and level of instructors.

II-7. M/W/DBE/SERB Participation. Prime Proposers are encouraged to utilize SERB vendor participation in their proposed solution. Responding firms shall clearly identify DBE/MBE/WBE firms, expected to participate in this contract, in their Proposal. If further information is desired concerning DBE/MBE/WBE participation, direct inquiries to the Pennsylvania Turnpike Commission’s Contract Administration Department by calling (717) 939-9551 Ext. 4241.

II-8. Questionnaire Responses. Proposers must respond to all questions posed in the Questionnaire section of this RFP related to the line of coverage being bid.

II-9. Cost Submittal. The information requested in this section shall constitute your cost submittal. The Cost Submittal shall be placed in a separate sealed envelope within the sealed proposal, separate from the technical submittal.

Proposers should not include any assumptions in their cost submittals. If the proposer includes assumptions in its cost submittal, the Issuing Office may reject the proposal. Proposers should direct in writing to the Issuing Office pursuant to Part I-9 of this RFP any questions about whether a cost or other component is included or applies. All Proposers will then have the benefit of the Issuing Office’s written answer so that all proposals are submitted on the same basis.

The total cost you are proposing must be broken down into the following components:

1) Please quote on an experience-rated basis and provide details (actual rate calculation) on how initial rates were calculated including a breakout of anticipated claims expenses (i.e. pure premium) and non-claims expenses (i.e. retention). Explain simply (verbally and through numeric example) how the proposed rates were developed from current claims experience including levels of discounts, assumed network utilization, etc.

2) Provide a breakdown of the components that make up retention and what percentage each component represents of total retention. For how long of a period of time is this retention percentage guaranteed?

3) Please detail your experience rating methodology and provide an example of a renewal calculation assuming each of the following:

   - Claims are 25% lower than expected
   - Claims are at the expected level
   - Claims are 25% higher than expected

4) What is the earliest a renewal and COBRA rates can be provided? Guaranteed?

5) Please describe all funding arrangements that you offer (i.e., Retrospective Credit, Retrospective Refund, Administrative Services Only (ASO), Prospective, etc.).

6) What has been your average Loss Ratio (paid and incurred) for each product offered over the past three years?
7) Please provide details on your "other party liability" functions including documentation of quantifiable savings.

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

9) Please describe in detail how the credibility of the group's experience is determined.

10) Please describe your current pooling level and how any applicable charge is calculated.

11) Describe how Rate Stabilization Fund (RSF) balances are returned or recovered in the renewal. Can they only be returned at the policy effective date without penalty?

12) What are the limits/caps that may be accumulated in the RSF? How are the surpluses over that limit refunded? How are deficits handled that exceed the limit? What interest rate is credited to the RSF?

13) What happens to balances in the RSF if the group chooses to terminate coverage? If the group returns, how are previous balances in the RSF handled?

14) Under a Retrospective Refund arrangement, when does the settlement process take place?

15) Are Margin Factors built into the Maximum Retrospective Refund Rates? If so, how are they calculated?

16) Under a Retrospective Refund arrangement, are the amounts of deficits/surpluses a group can accumulate limited? How are the deficits/surpluses handled if the limit is exceeded?

17) Will we be charged any access fees for doctors or physicians that you participate with in Pennsylvania? If so, please explain.

18) Broker Costs. Specify what amount is provided, e.g. percentage of the premium, etc.

19) Summary of all administrative costs and service fees associated with administration of the plan.

20) Total Cost.

**Administrative Services Only (ASO):**

21) Under an ASO arrangement, when does the settlement process take place, assuming a 12/12 stop loss? Assuming a 12/15 stop loss?

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

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

24) For which costs would the Commission be responsible when under an ASO or self-funded arrangement; i.e. printing costs, mailing costs, legal fees, set up fees, etc.?
Any costs not provided in the cost proposal will be assumed as no charge to the Commission.

Only work satisfactorily performed after execution of a written contract, after the contractor’s receipt of a notice to proceed from the Commission and after the contract term has begun will be reimbursed.
PART III

CRITERIA FOR SELECTION

III-1. Mandatory Responsiveness Requirements. To be eligible for selection, a proposal should be (a) timely received from a Proposer; (b) properly signed by the Proposer; and (c) formatted such that all cost data is kept separate from and not included in the Technical Submittal.

III-2. Proposals will be reviewed and evaluated by a committee of qualified personnel selected by the Commission. This committee will recommend for selection the proposal that most closely meets the requirements of the RFP and satisfies Commission needs. Award will only be made to a Proposer determined to be responsive and responsible in accordance with Commonwealth Procurement Code.

III-3. The following areas of consideration will be used in making the selection:

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

b. Proposer Qualifications. This refers to the ability of the Proposer to meet the terms of the RFP, especially the time constraint and the quality, relevancy, and recency of studies and projects completed by the Proposer. This also includes the Proposer’s financial ability to undertake a project of this size, ability to underwrite and administer the plans as requested, willingness to provide performance guarantees, and network accessibility.

c. Personnel Qualifications. This refers to the competence of professional personnel who would be assigned to the job by the Proposer. Qualifications of professional personnel will be measured by experience and education, with particular reference to experience on services similar to that described in the RFP. Particular emphasis is placed on the qualifications of the project or plan manager and the service reputation including performance standards.

d. Soundness of Approach. Emphasis here is on the techniques for collecting and analyzing data, sequence and relationships of major steps, and methods for managing the service/project. Of equal importance is whether the technical approach is completely responsive to all written specifications and requirements contained in the RFP and if it appears to meet Commission objectives.

e. Cost. The Commission reserves the right to select a proposal based upon all the factors listed above, and will not necessarily choose the firm offering the best price. The Commission will select the firm with the proposal that best meets its needs, at the sole discretion of the Commission.
PART IV

WORK STATEMENT

IV-1. Objectives.

   a. General. The Commission is soliciting proposals from qualified vendors for a three year contract with 2 one-year renewable extensions for the administration of its health care programs and services.

   b. Specific. The Commission is soliciting competitive proposals to reduce health care costs; provide high quality service, and to effectively manage and control claim information for the following benefit and insurance plans: Medical, Prescription, Dental, Vision, Cobra and Stop Loss.


Background. The Commission is an independent agency of the Commonwealth of Pennsylvania. As a government agency, the Commission is not governed by the rules, regulations, or legislative requirements of ERISA.

The Pennsylvania Turnpike is a key transportation route within the state of Pennsylvania and a vital link in the network of the eastern United States. The Pennsylvania Turnpike is 536 miles in length with 60 fare collection facilities, 20 service plazas and 2 welcome centers, 21 maintenance buildings, 8 police barracks and 5 tunnels. For more information, go to www.paturnpike.com.

Currently there are over 2,200 active employees of the Commission who work in over 110 locations including three administrative offices: the Central Administration Office in Middletown, PA, the Eastern Regional Office in King of Prussia, PA and the Western Regional Office in New Stanton, PA.
I. Instructions

Please be sure to carefully review these instructions prior to composing your response.

The current benefit and insurance plans and carriers in place are:

- Medical Indemnity – Highmark Blue Shield
- Dental – United Concordia Companies, Inc.
- Vision – National Vision Administrators, LLC
- Prescription Drug – Medco Health Solutions, Inc.
- COBRA – CobraServ
- Stop Loss – HM Insurance Group

Finalists will be selected and invited to present proposals to the Commission.

Please respond only to those sections that are applicable to the line(s) of coverage that you are presenting.

Complete benefit specifications are included in this marketing.

- Expect that these specifications will need to be duplicated unless you are specifically instructed otherwise.
- Any deviations from the plans requested must be clearly stated and could affect your standing as a finalist.
- Please quote all programs using the assumption that you may not be awarded all of the programs and may in fact be one of many carriers providing services to the Commission.
- Please identify any changes to your proposal if you are awarded only one of the plans presented.
- Your proposal should include a minimum of a 12-month rate guarantee from March 1, 2008. Please indicate your ability to provide multiple year administrative fee guarantees.

Your ability to provide a long-term financial commitment to the Commission will be viewed most favorably.
Documents

If you are selected as a finalist, you will be required to provide sample documents including, but not limited to:

- claims management reports
- large claim reports
- contracts
- employee benefits booklets
- financial illustrations
- online services
- HIPAA 834 Reports

Although the Commission is not governed by ERISA, it is preferred that all documents satisfy ERISA documentation standards including Summary Plan Description requirements.

Financing

All plans should be quoted on a fully insured basis utilizing a Retrospective Refund 90% Deposit approach (or your nearest equivalent) and on a self-insured basis. For self-insured proposals, please outline the different financial methods you can offer to accomplish a self insured plan.

All plans are to be effective March 1, 2008 and should include a minimum 120-day notice of annual renewal.

Eligibility

The 3,597-member enrollment of the Commission is divided into several categories including Union, Management and Retirees. Eligible employees include those working full-time and those considered “supplemental” or part-time.

No employee or retiree is to experience a loss of coverage as a result of a change in carrier or administrator. Evidence of Insurability will not be required of any individual on this plan.

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

Detailed plan information is included. Please be sure to match the benefits presented.

⇒ In the case of the Union plans, the benefits must be matched precisely to the current plans. If you are unable to match any provision of these Union plans, please highlight variances.
⇒ Union employees are not to be included for the dental and vision portion of this RFP. The Union has dental and vision coverage with the Teamsters Health & Welfare Fund.
⇒ The Commission is willing to entertain benefit enhancements on all plans and you are invited to present alternatives (i.e. PPO, POS); but bear in mind that the current plan must also be included.

All plans that include deductible and out of pocket maximum provisions should be quoted under the assumption that these amounts will be credited from the current plans. Dollars accumulated toward an individual’s lifetime maximum are to be carried over as well. Please confirm this in writing with your submission.

Format

Please use this RFP for your response by inserting your answers directly into the document following each question. Please be sure to format the text of your answer in such a manner as to make it easily distinguishable from the question. Your response should be submitted in hard copy and on CD.
II. Timeline

RFP Available for Issuance May 2, 2007
Questions due in Pennsylvania Turnpike Commission office May 10, 2007
Mandatory Pre-Proposal Conference May 14, 2007
Proposals Due in Pennsylvania Turnpike Commission office June 15, 2007
Provider Award/Approval October-November, 2007
Plan Effective Date March 1, 2008

Any changes to the above timeline prior to the proposal due date will be at the discretion of the Commission and will be posted to the website.

All information presented in the Request for Proposal and collected during the proposal process is considered confidential and is to be used only for the purpose of preparing your proposal and is not to be shared with anyone not directly involved in this process. Any breach of confidentiality is grounds for disqualification of your response.
III. Proposal Requirements

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

A. Administrative Requirements

1) The group contract holder is: Pennsylvania Turnpike Commission

   Mailing Address:   P.O. Box 67676
                    Harrisburg, PA 17106-7676

   Physical Address: 700 South Eisenhower Boulevard
                    Middletown, PA  17057

2) The effective date of the plan is March 1, 2008.

3) No participant will lose benefits as a result of a change in carrier (no loss/no gain).

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

5) The contract will cover dependents of eligible employees/retirees. This includes:
   b. Unmarried children to age 19, including:
      1. Stepchildren.
      3. Legally adopted children of the Contract holder or the spouse. An adopted child is considered acquired on the date when the Member takes active or constructive possession of the child.
      5. Any child for whom the Member is a legal guardian.

Dependent children who reach the age of 19 or who marry prior to age 19 will be removed from the contract at the end of the month in which such event occurs.
c. Unmarried children over age 19 remain eligible for coverage:

1. To age 25 (for the dental and vision programs students to age 23) if the child is a student enrolled full-time in an accredited university or college or in a technical or specialized school. An unmarried child over age 19 enrolled in a correspondence school is not a Dependent for purposes of this program.

In the case of full-time students, Dependent children will be removed from the contract at the end of the month in which they reach age 25, or they marry, or they cease to be full-time students prior to age 25.

d. To any age if the child is incapable of self-support due to mental retardation, physical handicap, mental illness or developmental disability, where the disability began before age 19. The disability must be medically certified by a Physician. The Plan may require proof of such Member’s disability from time to time.

e. Grandchildren of an employee/retiree are excluded as eligible Dependents except where:

1. Employee/Retiree has legally adopted the grandchild;
2. Employee/Retiree has obtained legal custody of the grandchild in accordance with a court order signed by a judge; or
3. Employee/Retiree is responsible for the sole support of the grandchild as a result of the death of his/her parents.

f. A newborn child of a Member will be considered a Dependent under this program for 31 days immediately following birth. If the member wishes to continue coverage for the newborn beyond that date, the infant must be enrolled for coverage.

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

- Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”)
- Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), including the nondiscrimination, special enrollment, coverage certification, and other HIPAA requirements;
- Mental Health Parity Act of 1996;
- Newborns’ and Mothers’ Health Protection Act of 1996; and the

As part of these obligations, you will provide continuation of coverage to qualified beneficiaries as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), track and provide former participants with HIPAA prior coverage certifications, and notify the Commission and participants in advance of a “material reduction” in health benefits. You will store, transmit, and communicate protected health information and protect the privacy of individually-identifiable health data as required under applicable federal and state law.

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

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

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

10) The cost of producing and mailing Evidence of Coverage (EOC) to employees must be included in your rates.

B. Financial Requirements

1) All rates are guaranteed for a minimum of 12 months, beginning March 1, 2008.

2) Rates provided will be composite and five-tier rate structures for insured programs and COBRA rates.

3) Annual rate renewals must be provided by November 1 for March 1 rate changes.

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

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

6) Premium payments will be based upon Commission enrollment numbers.
C. Administrative Service Expectations and Performance Guarantee

The Commission expects your benefit or insurance plan to provide premium service in administering benefits to our employees. To help accomplish that goal, we expect the plan to guarantee that the following administrative functions will be performed in a consistent and timely manner.

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

2) 99% of ID cards for ongoing enrollment will be accurate and mailed to the appropriate plan participants within 15 days of notification.

3) Claims reports, upon request, must be able to breakout Commission Management and Union benefits; show utilization by age/sex, employee/dependent status, and type of service; show enrollment info for specific time periods; and show benefit category by claim amount. Reports must comply with HIPAA regulations and cannot disclose Protected Health Information of employees unless exclusively requested by the Commission.

4) You must be able to support several group numbers and various types of benefits for both active and retired employees at no additional charge.

5) You must be able to produce a customized handbook, customized ID cards, electronic enrollment and delivery of handbooks no later than the date of plan implementation.

6) You must have separate dedicated customer service representatives at separate toll free telephone numbers to answer questions for both employees and the Human Resources department of the Commission.

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

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

_____ Without exception

_____ With exceptions described below

Exceptions:

Insurer or Plan Administrator: ___________________________
Location: ___________________________
Officer’s Signature: ___________________________
Officer’s Printed Name: ___________________________
Title: ___________________________
Date: ___________________________
IV. Questionnaire

A. GENERAL INFORMATION – ALL CARRIERS

1) Please describe your company, including:
   - Year founded
   - Area/Markets served (including counties)
   - Number of groups with over 3,000 lives covered
   - Number of members covered
   - Number of employees
   - Any Subsidiaries and/or Affiliates
   - Products offered

2) Please provide financial data on your company, as applicable, for each of the past three years to include but not limited to the following:
   - NCQA Ratings
   - AM Best Ratings
   - Standard & Poor's Rating
   - Annual Reports

3) What is the percentage of eligible employees that must be enrolled under your group plans?

4) Describe where you see your organization going in the next five years. Be sure to discuss, as applicable, network development, contracting approaches, reimbursement mechanisms, other changes, etc.

5) Please describe your customer service capabilities. Please give specifics regarding such items as speed to answer calls, abandoned call rate, turn around time on requests, training requirements of customer service representatives, and average years of experience of your customer service staff. Please outline the procedure an employee is to follow if satisfactory resolution is not received from your customer service staff.

6) Are you willing to provide a toll free dedicated customer service phone number to the employees of the Commission? To the Human Resources department for employer inquiries?

7) Who would be responsible for day-to-day service issues and problem resolution? Where is this individual located? Please provide a brief professional biography of the team leader responsible for daily issues regarding customer service, billing, claims and group related sales issues.

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

9) Please describe your electronic capabilities with respect to electronic and/or online enrollment, maintenance of eligibility records and access to electronic reports.
10) Please describe your Internet capabilities with respect to online directories, member access to claims, view/change enrollment data and ability to order ID cards, the ability to change physicians if applicable and other services available to members of the Commission.

11) Please describe your Internet capabilities with respect to online directories, employer access to claims, view/change enrollment data and ability to order ID cards, and other services available to Human Resources personnel of the Commission.

12) Are you capable of processing enrollment and record changes in accordance with HIPAA requirements? If so, please describe your experience with 834 interfacing.

13) Please describe your experience with the Systems, Applications and Products in Data Processing (SAP) system. Do you currently interface with any companies that use the SAP system? Explain the interface process. Would you be able to begin testing interfaces before the contract starts?

14) What is the location of the office that will process claims for the Commission? How many employees will be handling the processing of the claims and what is the average number of years of experience? Do you have a dedicated team supervisor? Will you provide a claims office visit during the final stage of the RFP process?

15) Please provide specific information regarding claims turnaround time and accuracy. Please include data on claims that are considered to be in your network and out of your network. Please describe the appeals process if a member believes a denied claim should have been paid.

16) Will you be having any major system changes that could affect enrollment, billing or claims in the next 12-24 months? If so, please explain. What assurances can you provide the Commission that these changes will not adversely affect their employees/retirees?

17) Please describe, in detail, your student certification process. Are dependent students removed monthly or annually? Can the removal interval be chosen? Do you provide notification directly to the member when certification expires?

18) Please provide specific information regarding Performance Guarantees especially as they pertain to claims turnaround and customer service problem resolution. Are you willing to provide a Performance Guarantee for both timeliness and accuracy with respect to Account Management and Claims Payment? What is the level of risk you are willing to place on a Performance Guarantee?

19) Are you willing to provide a Performance Guarantee with respect to the timely issuance and accuracy of identification cards, employee benefits booklets and program contracts? What is the level of risk you are willing to place on a Performance Guarantee?

20) Please provide a detailed implementation transition plan and timetable including but not limited to: plan setup and 834 interfacing.

21) Would you be willing to conduct a site visit for designated members of the Commission?

22) Please provide the following samples: Identification card, billing statement, Explanation of Benefits, and enrollment application.
23) Please describe in detail the reports that are available to the Commission. How much customization is available? Please provide a sample of the reporting package available to the Commission.

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

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

26) Please describe in detail any wellness programs that are available and how an employee would access these programs. Please include any additional costs if applicable.

27) Please provide three references of similar size and scope to the Commission. Please include two current customers and one former customer. Please include how long each has been/was a customer and the approximate number of employees.

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

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

30) When are the initial contracts and subsequent renewals presented for review and signature? How and when are contractual language changes presented to the employer? Please provide a sample contract.

31) How are the employee and employer notified of provider changes, network changes and coverage changes? Will the Commission be able to opt out of changes that violate union-negotiated benefits?

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

33) What are your means for obtaining Coordination of Benefits (COB) info? Describe COB procedures for in-network and out-of-network claims. How do you determine COB savings for Medicare eligibles? For non-Medicare eligibles? How often is this information updated?
B. MEDICAL CARRIERS ONLY

Network

1) How many networks can you offer to the Commission? Please include information (if applicable) regarding each network including the following:

- Year network organized
- Type (PPO, POS, Indemnity etc.)
- Organization's relationship to network (i.e., owned, affiliated, etc.)
- Current number of Hospitals, Ancillary facilities, PCP's, and Specialists under contract
- Number of the above that are JCAHO-accredited or board certified
- Number of Hospitals, Ancillary facilities, PCP's, and Specialists in network in each of the past 3 years
- Number of Hospitals, Ancillary facilities, PCP's, and Specialists in market area
- Number of PCP's and Specialists with closed practices as of January 1, 2007
- Hospital, PCP, and Specialist turnover numbers over the past 3 years (Network initiated and Provider initiated)
- Length of Contract (Hospital, Ancillary facilities, PCP, and Specialist)
- Length of Termination Notice (Hospital, Ancillary facilities, PCP, and Specialist)
- Percentage (%) of providers that participate in market area

2) Are your networks available nationwide? Describe how a member can access your network while traveling – within the U.S. and abroad.

3) Please provide a geo access report using the following standards: two Primary Care Physicians within an 8-mile radius; two Specialty Care providers within an 8-mile radius and one hospital within a 10-mile radius.

4) Please submit a comprehensive disruption analysis report illustrating any members whose current providers are not within your network.

5) Please provide two directories for each network quoted as well as an internet and telephone resource for network participation information.

6) Explain in detail any current plans you have to reconfigure your networks to meet the needs of the Commission. Include detailed timelines, work plans and names of the individuals responsible.

7) Would you be willing to develop networks in any locations where you do not now have acceptable access? What would be the time frame? Can an employee nominate a physician to participate in the network? Are you actively recruiting physicians for your network?

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

9) What processes will you use for disabled dependent certifications?
Administration

1) Explain in detail how members residing outside of your service area would be covered. Please explain how their benefits will be administered.

2) Do you offer Large Claim Management? Please describe your procedures.

3) Do you offer Case Management? Please describe your procedures.

4) Do you offer Disease Management programs? Please describe the programs available currently, any in development, and how a member would access these programs. Please indicate any additional cost for any of these programs.

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

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

7) Do you provide HIPAA Certification services? If so, what are your procedures and what are your fees? Please provide a sample of your HIPAA Continuation Certificate.
C. PRESCRIPTION CARRIERS ONLY

1) Please describe your retail pharmacy network including the number of pharmacies in Pennsylvania, the number outside of Pennsylvania and the percentage of pharmacies that participate. Please list the major pharmacy chains that participate in your network. Is your network accessible to members traveling abroad?

2) What is the location of the facility that will provide services for mail order prescriptions? How many employees are located at that facility? What are the quality assurance procedures in place to ensure all prescriptions are filled correctly and in a timely manner?

3) What is the average turnaround time for a new prescription to be filled? What is the average turnaround for a prescription to be refilled? Please describe the process for each.

4) Do you have a 24 hour phone number that members can call to speak with a pharmacist? To speak with a customer service representative? Can refills be ordered over the phone?

5) Please describe your internet capabilities with respect to online refills, drug information, over the counter purchases and network availability.

6) Does your processing system have a safeguard in place for drug interaction?

7) Please describe your network discounting strategy including percentage of discount on the retail and mail service level and any applicable dispensing or utilization management fees.

8) Do you participate with designated pharmacies for member long-term maintenance prescriptions up to a 90-day supply? Would the cost to the employee be the same as the mail order cost? If not, please indicate the cost difference. Would the retail dispensing fees apply?

9) Does your plan use a formulary? Is it open or closed? Are you willing to create a customized formulary for the Commission? Please enclose a copy of your formulary as well as an Internet and telephone resource for inquiries regarding the formulary.

10) How is your formulary list developed and by whom? How often is it changed?

11) Are exceptions made to the formulary? Please describe the process.

12) Do you offer formulary rebates? How often are they distributed? Are there any guarantees? Please explain.

13) How are specialty drugs handled? Are there limitations on how an employee may obtain specialty drugs? Please explain.

14) Do you offer coverage for diabetic supplies? Does the standard co-pay apply? Are they obtained by mail order or retail?

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

17) Can you provide retail or Internet-based discounts on non-covered prescriptions or over the counter products?

18) What services do you provide with regard to Medicare D and the employer drug subsidy? Do you have dedicated resources for Medicare processes? If so, please explain. Are there any costs associated with these services? If so, please provide any costs associated with Medicare D in your cost submittal.

19) Do you provide COBRA rates for self-insured companies? Are you able to deliver annual COBRA tiered rates for each group under the plan?
D. DENTAL CARRIERS ONLY

1) Please describe your network including number of dentists, oral surgeons, orthodontists, and other specialists in Pennsylvania, the number outside of Pennsylvania and the percentage of dentists that participate. Is your network accessible to members traveling abroad?

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

3) Please define your service area. Explain in detail how members residing outside of your service area would be covered. Please explain how their benefits will be administered.

4) Would you be willing to develop networks in locations where you do not now have acceptable access? What would be the time frame?

5) Please provide a geo-access report using the following standards: two General Dentists, two Oral Surgeons, two Orthodontists and two other specialists within an 8 mile radius.

6) Please submit a comprehensive disruption analysis report illustrating any members whose current providers are not within your network.

7) Please provide two directories for each network quoted as well as an internet and telephone resource for network participation information.

8) What are the financial arrangements if a dentist terminates his or her contract with your organization in the middle of the course of treatment of a patient?

9) What are the financial arrangements if a patient loses coverage in the middle of a course of treatment?

10) How are the following services covered under your plan?

   - Anesthesia
   - Pediatric dental specialist services
   - Hospitalization or attending physician due to the member's general health or physical limitations
   - Removal of impacted teeth; bony or soft tissue
   - Tooth implants
   - Extractions for orthodontic purposes
   - Periodontics, both surgical and non-surgical
   - Therapeutic Periodontal Treatment

11) Describe your preauthorization process; applicable procedures, and dollar thresholds.

12) Do you provide COBRA rates for self-insured companies? Are you able to deliver annual COBRA tiered rates?
E. VISION CARRIERS ONLY

1) Please describe your network including number of optometrists, ophthalmologists and opticians in Pennsylvania, the number outside of Pennsylvania and the percentage of each type of provider that participates. Please list the major “chain” providers in your network. Is your network accessible to members traveling abroad?

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

3) Please define your service area. Explain in detail how members residing outside of your service area would be covered. Please explain how they will be administered.

4) Would you be willing to develop networks in locations where you do not now have acceptable access? Under what conditions? What would be the time frame?

5) Please provide a geo-access report using the following standards: two Optometrists, two Ophthalmologists and two Opticians within an 8 mile radius.

6) Please submit a comprehensive disruption analysis report illustrating any members whose current providers are not within your network.

7) Please provide two directories for each network quoted as well as an internet and telephone resource for network information.

8) What are the financial arrangements if an ophthalmologist terminates his or her contract with your organization in the middle of the course of treatment of a patient?

9) What are the financial arrangements if a patient loses coverage in the middle of a course of treatment?

10) Are the allowances listed in your plan retail or wholesale? If the member receives additional services, i.e., two pairs of glasses; does the member pay the retail or wholesale price? Are you able to provide wholesale allowances to the Commission?

11) Is the network accredited by an outside organization? If Yes, by whom?

12) Is “Lasik” an option under your plan? Do you have any additional options of treatment that can be offered under the plan? Please define how you can cover these services.

13) Can you provide customized allowances for services such as frames and lenses?

14) Can you provide discounts or other coverage for items such as non-prescription sunglasses, safety goggles, additional pairs of glasses or contacts or colored contacts? Are there discounts available for supplies such as contact lens cleaning fluids?

15) Do you provide COBRA rates for self-insured companies? Are you able to deliver annual COBRA tiered rates?
F. COBRA CARRIERS ONLY

1) Describe in detail the COBRA services you provide.

2) Describe any special banking arrangements you require for administration of COBRA. Do you require any documents or security deposits?

3) Please provide the most recent audited financial statement or a “Statement of Conditions” if an audited financial statement is not applicable, for your firm.

4) Are you able to provide COBRA services for all benefits: medical, dental, vision and prescription? If so, please explain.

5) Does the administration of benefits differ from the fully insured to self insured?

6) Are you bidding on the medical, prescription, dental or vision coverage in this RFP? If so, please list.

7) Describe how the Commission should notify you of qualifying events (online services, data files, paper, faxes, email, etc.).

8) How is a COBRA participant enrolled in the medical plans? Do you provide enrollment/disenrollment services? Are there additional costs associated with the services? If so, please provide in the cost submittal.

9) What is the turnaround time for eligibility mailings? What do you include in your eligibility mailings? Provide a sample mailing.
G. STOP LOSS CARRIERS ONLY

1) Describe how the aggregate threshold is calculated (per employee/month).

2) What is the time line for aggregate and specific stop loss to be settled? Is reimbursement immediate or at the end of the year?

3) Describe any special banking arrangements you require for administration of stop loss. Do you require any documents or security deposits?

4) Describe what reports you would need from the claims administrator and the frequency with which these reports would be needed.

5) Are any individuals, classes of individuals and/or medical conditions excluded from coverage, reimbursed at a lower rate, capped or otherwise limited (e.g., mental health, substance abuse, organ transplants, COBRA participants, disabled or confined individuals, not actively-at-work employees, pre-existing conditions, etc.)?

6) Do you agree to provide coverage for all disabled or inactive individuals currently covered by the Commission’s medical plan? If you intend to separately evaluate any individuals, what are the possible outcomes (e.g., increase in specific stop loss, no coverage, higher rates, excluded conditions, etc.)?

7) Do you perform individual underwriting for stop loss purposes for the first or subsequent years? Can the specific stop loss limit change on individuals from year-to-year? In a renewal year, can individuals (or individual conditions) be excluded from coverage as a result of the prior year’s or expected medical claims?

8) Have you based your proposed specific stop loss rates on the Commission’s own shock claims and/or known or ongoing claims?

9) Will future years’ stop loss rates be entirely based on the experience of your stop loss pool or will the Commission’s own claim results (or known ongoing claims) play a factor in your rating?

10) Do you reserve the right to increase the specific stop loss pooling point from one year to the next?

11) Are the rates for the time period unconditionally guaranteed? In other words, do you reserve the right to change the quoted rates prior to implementation?

12) What additional information will you require from the Commission or the claims administrator prior to implementation?

13) Would there be any impact on stop loss for an off-anniversary contract termination?

14) What is the stop loss carrier’s philosophy regarding lasering?

15) Please provide the most recent audited financial statement or a “Statement of Conditions” if an audited financial statement is not applicable, for your firm.
V. Rate History

INDEMNITY – Self Insured Funding

Medical

Indemnity – Active Union and Union Retirees Under 65 after 2-1-05

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Indemnity – Active Management and Management Retirees Under 65 after 7-1-98

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Indemnity – Union Retirees Under 65 between 10-1-97 and 1-31-05

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65 Special – Management & Union Retirees Over 65

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## Indemnity - Management Retirees Under 65 Prior to 7-1-98 and Union Retirees Under 65 Prior to 10-1-97

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## Prescription – Active Management

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## Prescription – Active Union

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### Prescriptions – Union Retiree

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CORRECTION

On Page 6, Part II of the RFP the first paragraph states: “The submittals are as follows: (i) Technical Submittal, in response to Sections II-1 through II-7 hereof; (ii) Cost Submittal, in response to Section II-8 hereof.” This was printed in error. The corrected language is: “. . .Technical Submittal, in response to Sections II-1 through II-8 hereof; (ii) Cost Submittal, in response to Section II-9 hereof.”

Following are the answers to questions submitted in response to the above referenced RFP as of May 14, 2007. All of the questions have been listed verbatim, as received by the Pennsylvania Turnpike Commission.

CENSUS QUESTIONS:

1. Please provide the census in an excel spreadsheet including the following information:

   a. Each Employee's First & Last Name or Employee ID - Please list each Employee as "Employee"
   b. Each Dependent's First & Last Name or ID - Please list each Dependent as "Spouse", "Child", etc.
   c. Employee Status:
      - Active Union
      - Union Retirees Under 65 after 2-1-05
      - Active Management
      - Management Retirees Under 65 after 7-1-98
      - Union Retirees Under 65 between 10-1-97 and 1-31-05
      - 65 Special - Management
      - Union Retirees Over 65
      - Management Retirees Under 65 Prior to 7-1-98
      - Union Retirees Under 65 Prior to 10-1-97
      - Prescription - Active Management
      - Prescription - Active Union
      - Prescription - Management Retiree
      - Prescriptions - Retirees
      - COBRA
   d. Gender
   e. DOB
   f. Zip code
g. Type of Health Plan selected (Medical, Rx, Dental, Vision) Also, if there are multiple medical plans, dental or vision plans offered, please indicate which plan the employee has chosen.

h. Type of Coverage selected (Employee only, Employee + Spouse, Employee + Child(ren), Family, etc.)

i. Please include all employee's waiving coverage.

**Additional census data is provided on the addendum CD.**

The type of coverage selected (Employee only, Employee + Spouse, etc.) is not available.

Very few employees decline coverage since benefits are fully paid.

2. In order to complete the Cost Submittal, as requested, is the PTC willing to provide the following Census information in Excel format and further identifying the following:

   • Active Union Members by plan design and identifiers for Single, Husband & Wife, Parent & child, Parent & Children, and Family.
   • Retirees under age 65 by plan design
   • Retirees over age 65 by plan design.

**Additional census data is provided on the addendum CD.**

Identifiers for Single, Husband & Wife, etc. will not be provided.

3. Current census data – This data should identify retired, COBRA or other not actively at work employees and the data must include the following information:

   (excel format is preferred)

   1) Date of Birth
   2) Sex
   3) Single, Employee & Child, Employee & Spouse or Family coverage
   4) Active Union, Union Retiree under 65, Union Retiree over 65, Active Management, Management Retiree under 65, Management Retiree over 65
   5) CoverageSelected - Indemnity, PPO, POS, etc.
   6) Home zip code
   7) COBRA by category

**Additional census data is provided on the addendum CD.**

COBRA Categories (8 active):

   3 – Reduction of Hours
   1 – Termination/Resignation
   3 – Ineligible Dependent Child
   1 – Retirement

4. Can the census be sent in excel?

**Additional census data is provided on the addendum CD.**

5. Can the census be broken out by plan?

**Additional census data is provided on the addendum CD.**
GENERAL QUESTIONS:

6. Please provide the Benefit Highlights for all products (Medical, Rx Dental & Vision).

   Copies of all Certificates of Coverage/Summary Plan Descriptions for all products (Medical, Rx Dental & Vision).

   Monthly enrollment and monthly Claims Experience for each product (Medical, Dental, Vision & Rx) for the past 3 years.

   Copies of Certificates of Coverage will not be provided.
   Summary Plan Descriptions were included in the Appendices.
   Additional claims data is provided on the addendum CD.
   Monthly enrollment and claims experience for Prescription is not available.

   **Copies of Certificates of Coverage will not be provided.**
   Summary Plan Descriptions were included in the Appendices.
   Additional claims data is provided on the addendum CD.
   Monthly enrollment and claims experience for Prescription is not available.

7. At what percentage has the current carrier used registered vendors over the past 2 years? - is this a percentage of premium or of the retention component. (M/W/DBW/SERB)

   This information will not be provided.

8. Does the Commission have a target M/W/DBE/SERB participation percentage?

   Although there is no specific participation percentage assigned to this RFP, consideration will be given to proposers who have committed to utilize minority vendors in the evaluation process.

9. Page 14 states: “your response should be submitted in hard copy and on CD.” Please confirm whether eight CD-ROMs should be included with the hard copy requests. Also confirm whether or not eight hard copies and eight CD-ROMs are required for the Cost Submittal response.

   Yes.

10. Are the rates shown in pages 32 through 34 provided based on expected cost or maximum liability (including stop loss).

    Medical, prescription, dental and vision rates shown are expected cost. Stop Loss and Cobra rates shown are actual cost.

11. RFP stated “Premium Payments will be based upon Commission enrollment numbers.” Please clarify the requested billing method and provide an example for both fully insured and ASO methods.

    The Commission will review all submitted proposals.

12. Please clarify whether the HIPAA question on page 23 in the RFP pertains to the Administrative Simplification provisions of HIPAA (which include Transactions, Code Sets and Privacy) or Portability; or both?

    Administrative Simplification provisions.
13. Please clarify if there are any employees actively at work who are over age 65.

   Yes.

14. Employer’s Benefit Contribution: __100___%Employee __100___%Dependent

15. Detailed description of all present benefits. Please submit the current policy(ies), plan document(s) and/or employee booklet(s)(summary plan description). Please note any benefit changes during the experience period, by plan.

   Current policies and plan documents will not be provided.
   Summary Plan Descriptions were provided in the Appendices.

16. Paid claims utilization detail for all lines of coverage (separated by hospital inpatient/outpatient, medical, prescription drug, dental, vision, etc.) for the past three years. Excel format is preferred. Month by month history is preferable. Indicate the number of employees covered during the same period (again, month by month).

   Additional claims data is provided on the addendum CD.
   Monthly enrollment and claims experience for Prescription is not available.

17. The header on page 32 used the words "Self Insured Funding", yet on page 13 it seems as if the plans are fully insured with a Retrospective Refund arrangement. Please explain.

   The Commission is currently self insured but willing to consider all funding arrangements.

18. Is the Commission subject to PA State premium tax?

   No.

19. If self insured, can we have current administrative fees?

   We will not be providing any additional info regarding administrative fees.

20. If self-funded, please provide a copy of the current Administrative Services Agreement.

   This information will not be provided.

21. If currently on a Retrospective Refund arrangement: Can we be provided with the last 3 years of financial accounting packages to identify whether retrospective refunds or premium calls have occurred?

   We are not on a Retrospective Refund arrangement.

22. Request is for FI Retro Rated with 90% Deposit Approach & ASO; the Commission is currently ASO, why looking to go FI? Will we be considered if we quote ASO only?

   The Commission has not made a decision regarding funding arrangements. All submitted proposals will be considered.
23. Compensation: (page 8, # 18) are standard commission to be incorporated or does the Commission have specific guidelines?

   Standard commission should be included in the cost submittal. There are no specific guidelines.

24. Should the carrier use the same tier ratio to quote as the PTC?

   Yes.

25. Are Flexible Spending Account services needed?

   No.

26. Any subrogation claims or ongoing issues.

   Yes.

27. Will we be eliminated if we do not comply with the requested performance guarantees (i.e. would they accept our standards)?

   The Commission will review all submitted proposals.

28. RFP states we must be able to support several group numbers at no additional charge. Why does the Commission require multiple group numbers?

   In order to break down cost for budgeting employee/retiree benefit costs.

29. Is there a requirement that all claim processing be conducted within the US or can overseas operations be used?

   Overseas operations can be used.

30. When was the last time these coverages were out to bid?


31. Has the Commission hired a consultant to review bids?

   Currently in process.

32. Is the same consultant reviewing both portions of the bid?

   Yes.

33. When will the consultant begin?

   June.
MEDICAL QUESTIONS:

34. Traditional products typically do not cover preventive benefits. Are these benefits subject to the Major Medical deductible and coinsurance?

\textbf{No, they are covered 100\%}.

35. Please confirm that the Turnpike is not considering offering multiple medical carriers or multiple drug carriers on an insured basis.

\textbf{Correct}.

36. Can medical carriers bid on one segment of the population only (aka post 65 retirees)?

\textbf{No}.

37. Can the doctor listing be provided in excel for disruption purposes?

\textbf{Yes. Additional information is provided on the addendum CD.}

38. Please provide definitions for the headers on the medical claim report a) Provider charge; b) Customer Allowed Charge; c) Group Billed amount.

\begin{itemize}
  \item \textbf{a) Provider Charge-} The amount that the provider would charge for the services performed
  \item \textbf{b) Customer Allowed Charge-} The amount Highmark allows for the services performed
  \item \textbf{c) Group Billed Amount-} The amount charged back to the group for services performed (less i.e. deductibles, coinsurance)
\end{itemize}

39. Is the PTC willing to provide medical enrollment (contracts counts per month and member counts per month) for the following periods (to correspond to the claims information): 3/04-2/05; 3/05-2/06; 3/06-2/07. Like the claims, this data should be separated between actives and retirees over 65.

\textbf{Additional information is provided on the addendum CD.}

40. In order to complete the geo access report for medical, as requested, is the PTC willing to provide the following Census information in Excel format and further identifying the Active Union Members? The census file does not provide any distinction among the employees. There is no indication of union versus management versus retiree. Please confirm that the request is for a geo access report based on all eligible members.

\textbf{Additional information is provided on the addendum CD.}

41. In order to complete the comprehensive disruption analysis for medical, as requested, is the PTC willing to provide the following provider information?

\begin{itemize}
  \item Full Provider Name
  \item Complete Provider Address
  \item Tax Identification Number
\end{itemize}
These 3 data elements are required to produce a credible disruption analysis. The minimum requirements are full provider name and complete provider address. Other information can be provided, but it is not required. Please provide information in Excel format.

**Provider listings have been provided in the Appendices. They are provided in Excel format on the addendum CD.**

42. The RFP includes 5 separate provider listings (a total of 282 pages) for medical. The listings are (1) Top OP Facilities, (2) Top IP Facilities, (3) Top Facilities, (4) Specialists and (5) Primary Care Providers. Please clarify whether you are looking for a separate disruption analysis for each of the 5 listings.

   Yes.

43. Please clarify the PTC’s intention for large claim management. Is this in regard to high dollar cases, or something else?

   Yes, high dollar cases.

44. Number of Employees covered in Indemnity Plan: **2,162**
   
   Number of Employees in PPO/POS: **0**
   
   Number of Retirees covered: **808**
   
   Number of Disabled covered: **19**
   
   Number of COBRA covered: **8**

45. Is large medical claim information available ($75,000+ in paid claims)?

   **Additional claim information is provided on the addendum CD.**

46. Please itemize the disease management programs currently included in the medical plan rates.

   **Please refer to the Summary Plan Descriptions in the Appendices.**

47. Please itemize the wellness programs currently included in the medical plan rates.

   **We provide Preventative Benefits, however there are no incentives.**

48. How often are members going to in network providers (medical)?

   **Additional information is provided on the addendum CD.**

49. Any plan design changes within the last 2 years (medical)?

   **No.**

50. What are the current overall provider discounts being achieved (medical)?

   **This information will not be provided.**
PRESCRIPTION QUESTIONS:

51. Is the PTC willing to provide prescription drug enrollment (contracts counts per month and member counts per month) for the following periods (to correspond to the claims information): 3/04-2/05; 3/05-2/06; 3/06-2/07. Like the claims, this data should be separated between actives and retirees over 65.

   Monthly enrollment and monthly claims data is not available.

52. Is the PTC willing to provide additional information regarding Rx rebates and costs, i.e.: Are rebates included in the net RX cost? If not, what were the rebates for each reported period, i.e. 3/04-2/05; 3/05-2/06; 3/06-2/07?

   This information will not be provided.

53. What are the PTC’s expectations on Rx rebates, i.e. refunded, reductions in administrative costs, etc.?

   The Commission will review all submitted proposals.

54. Can you advise on the number of employees and members eligible for this program through Medco and impacted by the RFP?

   6,450 (Employees, retirees and dependents)

55. Are over-65 members included in the prescription “net cost?”

   Yes.

56. Is prescription “net cost” net of subsidy or prior to subsidy? Please supply “net cost” prior to subsidy.

   Net cost is prior to subsidy.

57. Please clarify whether the PTC currently files for the retiree drug subsidy.

   Yes.

58. Does the current prescription plan use any cost containment programs - Step Therapy, Mandatory Mail Order Drug, Automatic Generic Substitution, etc?

   Mandatory generic plans and maintenance prescription mail order incentives.

59. Is the pharmacy self insured? Please provide the current administrative fee.

   Yes. The administrative fees were provided in the RFP.

60. Please clarify if the PTC requires a geo access report for pharmacy network. If so, please provide parameter and zip code information.

   A geo access report for pharmacy is not required.
61. Please clarify the “maintenance” co pay/coinsurance benefits shown for the Active Union, Union Retirees over age 65 after 2/1/05, and Management Retirees over age 65 after 4/1/05. Is this “maintenance” benefit limited to a specific pharmacy or all pharmacies?

The maintenance copay applies to the third refill of a maintenance drug at a retail pharmacy. Maintenance drugs must be filled through mail order to avoid the higher copay.

62. If enrolled in medical, do members automatically receive RX coverage or can RX be selected on a standalone basis?

RX can be selected on a standalone basis.

**DENTAL QUESTIONS:**

63. In order to complete the geo access report for dental, as requested, is the PTC willing to provide Census information in Excel format for Management only members.

Additional information is provided on the addendum CD.

64. In order to complete the dental disruption analysis, as requested, is the PTC willing to provide dental utilization by provider for each member using UCCI dentists. Please provide this information in Excel format.

Additional information is provided on the addendum CD.

65. Is monthly experience, inclusive of lives, available for the previous three years (dental)?

Additional information is provided on the addendum CD.

66. What is the current dental in-network utilization?

Additional information is provided on the addendum CD.

67. How often are members going to in network providers (dental)?

Additional information is provided on the addendum CD.

68. What is the dental new hire eligibility period?

Management only; 1st of the month following date of hire.

69. What are the dental employer contributions for employees and dependents?

100%.

70. Please provide a complete dental benefit booklet from the current carrier?

No dental booklet available. Summary Plan Description was provided in the Appendices.
71. Are any dental services exempt from the deductible?

There is no deductible for dental coverage.

72. Is there presently a dental Reserve Stabilization Fund and, if so, what is the balance of the fund?

No.

73. Are the dental benefits provided on a contract or calendar year turnover?

Calendar year.

74. How many years has the incumbent carrier provided dental benefits?

The contract will be in place 5 years, ending 2/29/08.

75. Is there special out-of-network processing for dental? If so, at what level?

Out of network services may be submitted to the dental carrier but will be paid at the network’s negotiated maximum allowable charge.

76. Are there specific dental benefit enhancements the group would like to consider (increased annual maximum, etc.)?

The Commission will review all submitted proposals.

77. What are the current overall provider discounts being achieved (dental)?

This information will not be provided.

78. Is the dental self insured? Please provide the current administrative fee.

Yes. Administrative fees will not be provided.

79. Any plan design changes within the last 2 years (dental)?

Added implant coverage to the dental plan.

VISION QUESTIONS:

80. With regard to employees and retirees, please confirm they can get either two sets of glasses, contacts, or sunglasses, or a combination of the two, once every benefit period?

1 pair of glasses, 1 set of contacts, or 1 pair of sunglasses; 2 of the three, but not two of the same.

81. Outside of the $200 contact lens allowance, is there a discount (25%) on any coverages?

No plan design discounts, but we refer our members to Contact Fill.
82. With regard to the $50 lens allowance (for now-covered in full), can a member use this on multiple lenses? For example, could $15 be used for scratch coating, then the remaining $35 for polycarbonates?

   Yes.

83. Vision: rates have decreased each year from 2005-2008 forecast. Is this based on decreased plan utilization or decreased plan cost of care?

   Population and utilization since composite is based on both.

84. What are the top three factors upon which the vision contract decision be based? (Example: 1.Cost, 2.Network, 3.Administration)

   Please review part III of the RFP, Criteria for Selection.

**STOP LOSS QUESTIONS:**

85. Are your current stop loss rates available?

   Stop loss rates were provided on page 34 of the RFP.

86. Can we get current fees and stop loss rates?

   Stop loss rates were provided on page 34 of the RFP.

87. What will your position be on illustrative quotes for the stop-loss portion of the RFP?

   Illustrative quotes will be considered to be your firm and final proposal.

88. When will you require stop-loss carriers to firm their proposals?

   All firm proposals including cost submittal are due June 15, 2007.

89. Does the stop loss cover only Medical claims or both prescription and medical carrier?

   Medical only.

90. What are the current stop loss contract parameters (paid or 24/12 contract, medical only or includes RX?; stop loss level?)

   Medical only, contract basis is currently 180/12.

91. In order to complete the stop loss proposal, as requested, is the PTC willing to provide the following provider information?

   - HM Assurance stop loss contract for the following information:
     - contract basis (12/12, 12/15 PAID basis etc),
     - specific deductible level,
     - aggregate factors and aggregate premium if aggregated coverage is offered,
     - any special funding arrangements such as aggregating fund etc.,
• eligibility (are all employees covered under the specific or are some employees such as retirees over 65 excluded,
• anyone lasered with a higher deductible level, etc.

**Contract basis:** Currently 180/12  
**Specific Deductible:** $275,000  
**Aggregating Specific Loss Fund:** $90,000  
**Over 65 retirees are excluded from stop loss coverage.**  
There are no members lasered with a higher deductible level.

92. Three years of shock loss claims data for any claim that is at 50% of the specific and any claims that exceeded the specific deductible, including both diagnosis and prognosis. Specific reports requested are for the contract periods of March 2006 through February 2007, March 2005 through February 2006, March 2004 through February 2005, and any newly reported shock loss claims for period of March-April, 2007

**Additional information is provided on the addendum CD.**

93. Identify any claims of $20,000 or more (or 50% of the specific deductible attachment point) according to the following:

1) Individual incurring the claim  
2) Diagnosis  
3) Date claim incurred  
4) Date payments made  
5) Prognosis  
6) Is individual still covered by the plan?

**Additional claims information is provided on the addendum CD.**  
**Prognosis information will not be provided.**

94. If the case is self-funded, provide the current specific deductible and the existing contract basis, i.e., 12/12, 12/15, etc. and the current aggregate loss fund factor.

**Current contract basis is 180/12.**  
**Specific Deductible $275,000.**  
**Aggregating Specific Loss Fund $90,000.**

95. Copy of latest premium invoice indicating current premium and number of employees and dependents listed by category and family status by line of coverage. If the group is self-funded, submit a copy of the latest invoice indicating administration fees, specific and aggregate stop loss rates and premium.

**Copy of invoice and administration fees will not be provided.**  
**Specific Deductible $275,000.**  
**Aggregating Specific Loss Fund $90,000.**

96. What exactly does the 180 refer to? If 180 months, does that mean that a claim incurred 5 years ago that pays during the contract is counted under stop loss?

**180/12 means any claims incurred in the prior 180 months and paid in the current 12 months.**
97. Can you clarify the 180/12 month stop loss statement? Does the 180 refer to the run-in run-out?

    **180/12 means any claims incurred in the prior 180 months and paid in the current 12 months.**

98. Is this a paid contract?

    **Vendors will be paid according to contract specifications.**

**COBRA QUESTIONS:**

99. Will the Commission be providing any COBRA experience? How many people are on COBRA and how many events occur each month?

    **Currently there are 8 people on COBRA.**
    **Average of 18 events occur each month.**

100. Cobra services; are electronic services being provided and produced?

    **Yes, with the exception of enrollments.**

All other terms, conditions and requirements of the original RFP dated May 2, 2007 remain unchanged unless modified by this Addendum.
<table>
<thead>
<tr>
<th>COMPANY NAME</th>
<th>REP NAME</th>
<th>ADDRESS</th>
<th>PHONE</th>
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</thead>
<tbody>
<tr>
<td>2) National Vision Administrators</td>
<td>Melissa Sanks</td>
<td>4900 Lewis Dr., Suite 100, Mechanicsburg, PA 17055</td>
<td>717-732-7823</td>
<td>Gk@<a href="mailto:man@e-nva.com">man@e-nva.com</a></td>
</tr>
<tr>
<td>3) Health America/Covington</td>
<td>Steve Colvin</td>
<td>220 W Philadelphia St., York, PA</td>
<td>717-554-4045</td>
<td><a href="mailto:scolin@covington.com">scolin@covington.com</a></td>
</tr>
<tr>
<td>4) EyeMed Vision Care</td>
<td>Stephanie Moran</td>
<td>4000 Laxton Dr., Phoenix, AZ</td>
<td>(513) 705-3074</td>
<td><a href="mailto:smerritt@evedvision.com">smerritt@evedvision.com</a></td>
</tr>
<tr>
<td>5) Medco Health Solutions, Inc</td>
<td>Eran Hogoski</td>
<td>100 Pennsylvania Ave., Parkland, PA 26126</td>
<td>(610) 269-3371</td>
<td><a href="mailto:eom-hogs@medco.com">eom-hogs@medco.com</a></td>
</tr>
<tr>
<td>6) United Healthcare</td>
<td>Rich Brooks</td>
<td>1800 Benge St., Suite 300, Philadelphia, PA</td>
<td>(215) 860-6810</td>
<td><a href="mailto:sbrooks@uhc.com">sbrooks@uhc.com</a></td>
</tr>
<tr>
<td>7) United Healthcare</td>
<td>Robert Sickler</td>
<td>1234 Main St., 200 Phil, PA 17010</td>
<td>(215) 860-6810</td>
<td><a href="mailto:sbrooks@uhc.com">sbrooks@uhc.com</a></td>
</tr>
<tr>
<td>8) Highmark, Inc.</td>
<td>Lyn Graham</td>
<td>100 Senate Ave., Camp Hill, PA</td>
<td>717-302-2077</td>
<td><a href="mailto:Lyn@allmark.com">Lyn@allmark.com</a></td>
</tr>
<tr>
<td>9) Highmark Benefits Administrators</td>
<td>Lyn Graham</td>
<td>100 Senate Ave., Camp Hill, PA</td>
<td>717-302-2077</td>
<td><a href="mailto:Lyn@allmark.com">Lyn@allmark.com</a></td>
</tr>
<tr>
<td>10) Highmark Insurance Group</td>
<td>Lyn Graham</td>
<td>100 Senate Ave., Camp Hill, PA</td>
<td>717-302-2077</td>
<td><a href="mailto:Lyn@allmark.com">Lyn@allmark.com</a></td>
</tr>
<tr>
<td>11) Capital Blue Cross</td>
<td>J. DePace</td>
<td>1000 E, Commerce Ave., Harrisburg, PA</td>
<td>717-571-7879</td>
<td><a href="mailto:JDePace@CapitalBlueCross.com">JDePace@CapitalBlueCross.com</a></td>
</tr>
<tr>
<td>12) Capital Blue Cross</td>
<td>Jim Murphy</td>
<td>200 Commerce Ave., Harrisburg, PA</td>
<td>717-571-6956</td>
<td><a href="mailto:JimMurphy@CapitalBlueCross.com">JimMurphy@CapitalBlueCross.com</a></td>
</tr>
<tr>
<td>13) Delta Dental</td>
<td>Tony Reese</td>
<td>1000 Duke Dr., Mechanicsburg, PA</td>
<td>717-766-8658</td>
<td><a href="mailto:treese@deltadental.com">treese@deltadental.com</a></td>
</tr>
<tr>
<td>14) Direct Sales/Drugstore</td>
<td>Jim Hallman</td>
<td>601 S, Park Dr., 100, Harrisburg, PA</td>
<td>717-572-8010</td>
<td><a href="mailto:jhallman@d43pa.com">jhallman@d43pa.com</a></td>
</tr>
<tr>
<td>15) Vision Benefits of America</td>
<td>Steve Colvin</td>
<td>220 W Philadelphia St., York, PA</td>
<td>717-554-4045</td>
<td><a href="mailto:scolin@vantageagency.com">scolin@vantageagency.com</a></td>
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<tr>
<td>UCHealth Insurance</td>
<td>Kevin Kelleror</td>
<td>301 Market Ave #200</td>
<td>(913) 220-6712</td>
<td><a href="mailto:kelleror@uchealthins.com">kelleror@uchealthins.com</a></td>
</tr>
<tr>
<td>Wachovia Securities</td>
<td>Kevin Kelleror</td>
<td>600 W. Quarry Rd #1015</td>
<td>(412) 693-2934</td>
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<td>Actua</td>
<td>Kevin Kelleror</td>
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<tr>
<td>Highmark</td>
<td>Kevin Kelleror</td>
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<tr>
<td>Delta Dental, VSP Vi-</td>
<td>Kevin Kelleror</td>
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<td>CIGNA</td>
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<td>Endurance Admins</td>
<td>Kevin Kelleror</td>
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<tr>
<td>MVP Life Guardian</td>
<td>Kevin Kelleror</td>
<td></td>
<td>(800) 230-6712</td>
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<tr>
<td>Wach 2014</td>
<td>Richard Welsh</td>
<td>2240 Business Pk</td>
<td>610-397-2531</td>
<td><a href="mailto:richard.welsh@wachovia.com">richard.welsh@wachovia.com</a></td>
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<tr>
<td>Delta Dental of PA</td>
<td>Chris Davis</td>
<td>One Delta Drive, Mechanicsburg, PA</td>
<td>717-383-7352</td>
<td><a href="mailto:chris.davis@delta.org">chris.davis@delta.org</a></td>
</tr>
<tr>
<td>AETNA</td>
<td>Lisa Marie Hopkins</td>
<td>302 W 21st St, Suite 300, PA</td>
<td>815-775-0434</td>
<td>HopkinsLACGMLA.com</td>
</tr>
<tr>
<td>Vision Service Plan</td>
<td>Larry Opperman</td>
<td>4510 Redwood Village Lane, Hoosac, NY</td>
<td>320-699-9240</td>
<td><a href="mailto:Larry.Opperman@USF.com">Larry.Opperman@USF.com</a></td>
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</table>
Please make note of the following revision in regard to RFP 07-113-3531:

**DELETION**

On Page 1, Part I of the RFP, in Section I-7., the following language has been *deleted*:

“A firm that responds to this solicitation as a prime may not be included as a designated subcontractor to another firm that responds to the same solicitation. **Multiple responses under any of the foregoing situations may cause the rejection of all responses of the firm or firms involved.** This does not preclude a firm from being set forth as a designated subcontractor to more than one prime contractor responding to the project advertisement.”

All other terms, conditions and requirements of the original RFP dated May 2, 2007, remain unchanged unless modified by this or any other Addenda.