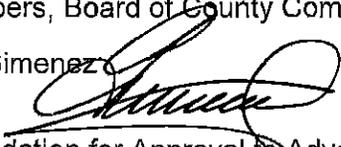


**Date:** May 5, 2015

**To:** Honorable Chairman Jean Monestime  
and Members, Board of County Commissioners

**From:** Carlos A. Gimenez  
Mayor 

**Subject:** Recommendation for Approval to Advertise Request for Proposals No. RFP-00196, Self-Funded Employee Group Healthcare Program

Agenda Item No. 8(F)(13)

Resolution No. R-396-15

### Recommendation

It is recommended that the Board of County Commissioners (Board) approve Request for Proposals No. RFP-00196, Self-Funded Employee Group Healthcare Program (RFP) in substantially the form attached and authorize the County Mayor or the County Mayor's designee to advertise the RFP.

A recommendation for award of any contract resulting from this solicitation shall be presented to the Board for approval. The Board will be notified of any addenda issued during the advertisement period when the award recommendation is presented to the Board.

### Scope

This impact of this item is countywide.

### Fiscal Impact

The final amount of the contract, funding source, and term will be presented to the Board once there is a recommendation to award.

### Track Record/Monitoring

Maria Carballeira, Procurement Contracting Officer in the Internal Services Department, will manage the solicitation. Technical support will be provided by the Human Resources Department.

### Background

On April 23, 2015, the Board held a policy discussion regarding the RFP and directed the Administration to present a final RFP at its May 5, 2015 meeting in the form of an approval to advertise.

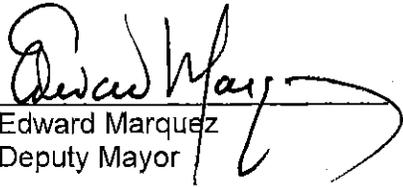
Attached for the Board's consideration is the solicitation for the County's Self-Funded Employee Group Healthcare Program. This version differs from the earlier version in that it includes the Proposer Information/Questionnaire and delineates performance standards for the Wellness and Disease Management Programs, as discussed at the April 23, 2015 Board meeting. The Internal Services and Human Resources departments, in consultation with the County's benefits consultant, have worked closely to prepare this competitive solicitation. Additionally, the following labor unions provided direct input: AFSCME 199, General; AFSCME 1542, Aviation; AFSCME 3292 Solid Waste; and General Government Supervisors Union. Furthermore, notification has been provided to all labor unions regarding the posting of this RFP as a future solicitation.

Proposals are being requested from qualified vendors to provide third-party administration services for the County's Healthcare Program. The County seeks a plan design that mirrors the County's existing benefit options, with the inclusion of robust wellness and disease management programs. Additionally, proposers are highly encouraged to propose up to two (2) alternative plan options that target cost savings for the County and its employees. Any changes to the County's current plan design would have to be negotiated with our labor unions.

Honorable Chairman Jean Monestime  
and Members, Board of County Commissioners  
Page 2

Before its completion, the scope of services for this RFP in various draft forms was posted for industry comment on multiple occasions (February 10, March 24, April 13 and April 16, 2015) for an aggregate period of four (4) weeks. An award will be made to a responsive, responsible proposer based on the best value to the County. The solicitation has been reviewed and approved by the Internal Services and Human Resources departments, and reviewed for legal sufficiency by the County Attorney's Office.

Attachment



Edward Marquez  
Deputy Mayor



# MEMORANDUM

(Revised)

**TO:** Honorable Chairman Jean Monestime  
and Members, Board of County Commissioners

**DATE:** May 5, 2015

**FROM:**   
R. A. Cuevas, Jr.  
County Attorney

**SUBJECT:** Amended  
Agenda Item No. 8(F)(13)

Please note any items checked.

- "3-Day Rule" for committees applicable if raised
- 6 weeks required between first reading and public hearing
- 4 weeks notification to municipal officials required prior to public hearing
- Decreases revenues or increases expenditures without balancing budget
- Budget required
- Statement of fiscal impact required
- Ordinance creating a new board requires detailed County Mayor's report for public hearing
- No committee review
- Applicable legislation requires more than a majority vote (i.e., 2/3's \_\_\_\_, 3/5's \_\_\_\_, unanimous \_\_\_\_ ) to approve
- Current information regarding funding source, index code and available balance, and available capacity (if debt is contemplated) required

Approved \_\_\_\_\_ Mayor  
Veto \_\_\_\_\_  
Override \_\_\_\_\_

Amended  
Agenda Item No. 8(F)(13)  
5-5-15

RESOLUTION NO.      R-396-15

RESOLUTION APPROVING REQUEST FOR PROPOSALS, RFP-00196, FOR A SELF-FUNDED EMPLOYEE GROUP HEALTHCARE PROGRAM FOR MIAMI-DADE COUNTY AND AUTHORIZING THE COUNTY MAYOR OR COUNTY MAYOR'S DESIGNEE TO ADVERTISE; PRESERVING COUNTY MAYOR'S DELEGATED AUTHORITY UNDER SECTION 2-8.1 OF THE COUNTY CODE INCLUDING THE AUTHORITY TO ISSUE ADDENDA AS NECESSARY DURING ADVERTISEMENT PERIOD; DIRECTING COUNTY MAYOR TO INCLUDE IN MEMORANDUM TO THE BOARD RECOMMENDING AWARD DESCRIPTION OF ADDENDA, IF ANY

**WHEREAS**, this Board desires to accomplish the purpose outlined in the accompanying memorandum, a copy of which is incorporated herein by reference,

**NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF MIAMI-DADE COUNTY, FLORIDA**, that this Board approves the Request for Proposals, RFP-00196, in substantially the form attached hereto, deleting the evaluation criteria for the Alternative Plan Options and the associated 70 points in Section 4.2(A)(4) of the RFP, and authorizes the County Mayor or the County Mayor's designee to advertise same to solicit proposals from qualified vendors to administer the County's self-funded employee group healthcare program. The time from solicitation release date to proposal submission due date shall be no less than six weeks. The County Mayor is authorized to exercise all delegated authority under Section 2-8.1 of the County Code, including the County Mayor's authority to issue addenda as necessary to address issues that may arise during the period the RFP is advertised. The County Mayor shall include in the memorandum to the Board recommending award, what addenda, if any, were issued.

The foregoing resolution was offered by Commissioner **Esteban L. Bovo, Jr.**, who moved its adoption. The motion was seconded by Commissioner **Audrey M. Edmonson** and upon being put to a vote, the vote was as follows:

	Jean Monestime, Chairman	aye		
	Esteban L. Bovo, Jr., Vice Chairman	aye		
Bruno A. Barreiro	aye	Daniella Levine Cava	absent	
Jose "Pepe" Diaz	aye	Audrey M. Edmonson	aye	
Sally A. Heyman	aye	Barbara J. Jordan	aye	
Dennis C. Moss	absent	Rebeca Sosa	aye	
Sen. Javier D. Souto	absent	Xavier L. Suarez	absent	
Juan C. Zapata	aye			

The Chairperson thereupon declared the resolution duly passed and adopted this 5<sup>th</sup> day of May, 2015. This resolution shall become effective upon the earlier of (1) 10 days after the date of its adoption unless vetoed by the County Mayor, and if vetoed, shall become effective only upon an override by this Board, or (2) approval by the County Mayor of this Resolution and the filing of this approval with the Clerk of the Board.



MIAMI-DADE COUNTY, FLORIDA  
BY ITS BOARD OF  
COUNTY COMMISSIONERS

HARVEY RUVIN, CLERK

By: **Christopher Agrippa**  
Deputy Clerk

Approved by County Attorney as  
to form and legal sufficiency.

Oren Rosenthal



**REQUEST FOR PROPOSALS (RFP) No. 00196  
FOR  
SELF-FUNDED EMPLOYEE GROUP HEALTHCARE PROGRAM**

**PRE-PROPOSAL CONFERENCE TO BE HELD:**

\_\_\_\_\_, 2015 at \_\_:00 AM (local time)  
111 NW 1<sup>st</sup> Street, 13<sup>th</sup> Floor, Conf. Rm. \_\_, Miami, Florida

**ISSUED BY MIAMI-DADE COUNTY:**

Internal Services Department, Procurement Management Services Division  
for  
Human Resources Department

**COUNTY CONTACT FOR THIS SOLICITATION:**

Maria Carballeira, Procurement Contracting Officer  
111 NW 1<sup>st</sup> Street, Suite 1300, Miami, Florida 33128  
Telephone: (305) 375-4260  
E-mail: mc5@miamidade.gov

**PROPOSAL RESPONSES DUE:**

**INSERT DATE AND TIME**

Electronic proposal responses to this RFP are to be submitted through a secure mailbox at BidSync until the date and time as indicated in this document. It is the sole responsibility of the Proposer to ensure its proposal reaches BidSync before the Solicitation closing date and time. There is no cost to the Proposer to submit a proposal in response to a Miami-Dade County solicitation via BidSync. Electronic proposal submissions may require the uploading of electronic attachments. The submission of attachments containing embedded documents or proprietary file extensions is prohibited. All documents should be attached as separate files. All proposals received and time stamped through the County's third party partner, BidSync, prior to the proposal submittal deadline shall be accepted as timely submitted. The circumstances surrounding all proposals received and time stamped after the proposal submittal deadline will be evaluated by the procuring department in consultation with the County Attorney's Office to determine whether the proposal will be accepted as timely. Proposals will be opened promptly at the time and date specified. The responsibility for submitting a proposal on or before the stated time and date is solely and strictly the responsibility of the Proposer. BidSync Customer Service Representatives are available at 1-800-990-9339 (8AM-8PM) EST. The County will in no way be responsible for delays caused by technical difficulty or caused by any other occurrence. All expenses involved with the preparation and submission of proposals to the County, or any work performed in connection therewith, shall be borne by the Proposer(s).

A Proposer may submit a modified proposal to replace all or any portion of a previously submitted proposal up until the proposal due date. The County will only consider the latest version of the proposal. For competitive bidding opportunities available, please visit the County's Internal Services Department website at: <http://www.miamidade.gov/procurement/>.

Requests for additional information or inquiries must be made in writing and submitted using the question/answer feature provided by BidSync at [www.bidsync.com](http://www.bidsync.com). The County will issue responses to inquiries and any changes to this Solicitation it deems necessary in written addenda issued prior to the proposal due date (see addendum section of BidSync Site). Proposers who obtain copies of this Solicitation from sources other than through BidSync risk the possibility of not receiving addenda and are solely responsible for those risks.

## 1.0 PROJECT OVERVIEW AND GENERAL TERMS AND CONDITIONS

### 1.1 Introduction

Miami-Dade County, hereinafter referred to as the County, as represented by the Human Resources Department, is soliciting for proposals from qualified organizations interested in providing full administrative services, including but not limited to imaging, pharmacy benefits management, disease management and wellness program services, for the County's Self-Funded Employee Group Healthcare Program (Program) for Plan Year 2016, effective January 1, 2016. The County is not currently interested in Stop-Loss coverage.

**Note:** The County reserves the right, at any time during the term of any resultant agreement, to carve-out any component/service of the Program (i.e., pharmacy, wellness, etc.) that is determined to be more beneficially served as a separate program, or in combination with another program, at its sole discretion.

The County anticipates awarding a contract for five (5) plan years, with one (1) option to renew, consisting of twenty-four (24) months, at the County's sole discretion.

#### The anticipated schedule for this Solicitation is as follows:

Solicitation Issued:	May --- 2015
Pre-Proposal Conference:	See front cover for date, time, and place. Attendance is recommended but not mandatory. If you need a sign language interpreter or materials in accessible format for this event, please call the ADA Coordinator at (305) 375-2013 or email <a href="mailto:hjwrig@miamidadegov">hjwrig@miamidadegov</a> at least five days in advance.
Deadline for Receipt of Questions:	
Proposal Due Date:	See front cover for date and time.
Evaluation Process:	June - July, 2015
Projected Award Date:	September, 2015

### 1.2 Definitions

The following words and expressions used in this Solicitation shall be construed as follows, except when it is clear from the context that another meaning is intended:

1. The words "Cafeteria Plan" to mean a plan that offers flexible benefits under the Internal Revenue Service (IRS) Code Section 125. Employees choose their benefits from a menu of cash and benefits, some of which can be paid with pretax deductions from wages.
2. The word "Contractor" to mean the Proposer that receives any award of a contract from the County as a result of this Solicitation, also to be known as "the prime Contractor".
3. The word "County" to mean Miami-Dade County, a political subdivision of the State of Florida.
4. The words "Custom Formulary" to mean a list of covered pharmaceuticals under the County's existing Program.
5. The words "Eligible Member" to mean active employee, their spouse or domestic partner.
6. The word "Gatekeeper" to mean a primary care physician who is responsible for the administration of the patient's treatment. The Gatekeeper coordinates and authorizes all medical services, laboratory studies, specialty referrals and hospitalizations.
7. The words "Medical Necessity" to mean accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.
8. The words "Plan Design or Plan" to mean designed benefit option to establish a course of healthcare.
9. The words "Program" to mean the self-funded employee benefit plan established and maintained by the County that provides healthcare for employees and their dependents. The word "Member" to mean all employees, retirees, and their dependents enrolled in the Program.
10. The words "Narrow, Tailored and High Performance Networks" are all terms used to describe similar types of benefit plans which have costs substantially lower than traditional open access HMOs or standard PPO/POS offerings.
11. The words "Open Access HMO" to mean an HMO (health maintenance organization) plan that only allows Members to receive treatment within the HMO network. Additionally, members can visit a specialist without first obtaining a referral from their primary doctor. HMO Open Access plans still restrict Members to the network, but provide for freedom to visit specialists without a referral.
12. The word "On-site" to mean location where County provides office space for Contractor's staff, currently at 111 NW 1<sup>st</sup> Street, Miami Dade, Florida, 33128.

13. The word "Participant" to mean all employees and eligible dependents who choose to participate in the Disease Management Program; and employees and their spouse or domestic partner who choose to participate in the Wellness Program
14. The words "Plan Year" to mean calendar year, January 1 through December 31.
15. The word "Proposal" to mean the properly signed and completed written submission in response to this solicitation by a Proposer for the Services, and as amended or modified through negotiations.
16. The word "Proposer" to mean the person, firm, entity or organization, as stated on the Solicitation Submittal Form, submitting a response to this Solicitation.
18. The word "Provider" to mean medical/pharmaceutical professional rendering services under the Program.
19. The words "Scope of Services" to mean Section 2.0 of this Solicitation, which details the work to be performed by the Contractor.
20. The words "Self-funded Program" to mean a program offered by employers who directly assume all or part of the risk for the payment of claims.
21. The word "Solicitation" to mean this Request for Proposals (RFP) document, and all associated addenda and attachments.
22. The word "Subcontractor" to mean any person, firm, entity or organization, other than the employees of the Contractor, who contracts with the Contractor to furnish labor, or labor and materials, in connection with the Services to the County, whether directly or indirectly, on behalf of the Contractor.
23. The word "Subscriber" to mean person whose employment makes them eligible for group health insurance benefits.
24. The words "Tiered HMO" to mean a benefit program offered within South Florida (i.e., Miami-Dade, Broward and Palm Beach Counties), wherein each time a Member seeks care from a Primary Care Physician (PCP) or hospital, the cost sharing is based on the tier the provider is assigned to. Members must consider the cost and quality of their PCP and/or hospital each time they seek medical care.
  - a. Enhanced Benefits Tier— Hospitals and PCPs that meet the standards for quality and low cost relative to the County's existing Plan's network.
  - b. Standard Benefits Tier— Hospitals and PCPs that meet the standards for quality and moderate cost relative to the County's existing Plan's network and benchmark. Standard Benefits Tier also includes providers without sufficient data for measurement on one or both benchmarks. To ensure Members have provider access in certain geographic areas, the Standard Benefits Tier includes some providers whose scores would otherwise put them in the Basic Benefits Tier.
  - c. Basic Benefits Tier— Hospitals that meet the standards for quality and are high cost relative to the County's existing Plan's network; and PCPs that do not meet the standards for quality and/or high cost relative to established benchmark.
25. The words "Wellness Program" to mean both wellness and disease management program services.
26. The words "Work", "Services", "Program", or "Project" to mean all matters and things that will be required to be done by the Contractor in accordance with the Scope of Services and the terms and conditions of this Solicitation.

### **1.3 General Proposal Information**

The County may, at its sole and absolute discretion, reject any and all or parts of any or all responses; accept parts of any and all responses; further negotiate project scope and fees; postpone or cancel at any time this Solicitation process; or waive any irregularities in this Solicitation or in the responses received as a result of this process. In the event that a Proposer wishes to take an exception to any of the terms of this Solicitation, the Proposer shall clearly indicate the exception in its proposal. No exception shall be taken where the Solicitation specifically states that exceptions may not be taken. Further, no exception shall be allowed that, in the County's sole discretion, constitutes a material deviation from the requirements of the Solicitation. Proposals taking such exceptions may, in the County's sole discretion, be deemed nonresponsive. The County reserves the right to request and evaluate additional information from any respondent regarding respondent's responsibility after the submission deadline as the County deems necessary.

The submittal of a proposal by a Proposer will be considered a good faith commitment by the Proposer to negotiate a contract with the County in substantially similar terms to the proposal offered and, if successful in the process set forth in this Solicitation and subject to its conditions, to enter into a contract substantially in the scope and terms, as set forth herein. Proposals shall be irrevocable until contract award unless the proposal is withdrawn. A proposal may be withdrawn in writing only, addressed to the County contact person for this Solicitation, prior to the proposal due date or upon the expiration of 180 calendar days after the opening of proposals.

Proposers are hereby notified that all information submitted as part of, or in support of proposals will be available for public inspection after opening of proposals, in compliance with Chapter 119, Florida Statutes, popularly known as the "Public Record Law". The Proposer shall not submit any information in response to this Solicitation which the Proposer considers to be a trade secret, proprietary

or confidential. The submission of any information to the County in connection with this Solicitation shall be deemed conclusively to be a waiver of any trade secret or other protection, which would otherwise be available to Proposer. In the event that the Proposer submits information to the County in violation of this restriction, either inadvertently or intentionally, and clearly identifies that information in the proposal as protected or confidential, the County may, in its sole discretion, either (a) communicate with the Proposer in writing in an effort to obtain the Proposer's written withdrawal of the confidentiality restriction or (b) endeavor to redact and return that information to the Proposer as quickly as possible, and if appropriate, evaluate the balance of the proposal. Under no circumstances shall the County request the withdrawal of the confidentiality restriction if such communication would in the County's sole discretion give to such Proposer a competitive advantage over other proposers. The redaction or return of information pursuant to this clause may render a proposal non-responsive.

Any Proposer who, at the time of proposal submission, is involved in an ongoing bankruptcy as a debtor, or in a reorganization, liquidation, or dissolution proceeding, or if a trustee or receiver has been appointed over all or a substantial portion of the property of the Proposer under federal bankruptcy law or any state insolvency law, may be found non-responsive. To request a copy of any ordinance, resolution and/or administrative order cited in this Solicitation, the Proposer must contact the Clerk of the Board at (305) 375-5126.

#### 1.4 Cone of Silence

Pursuant to Section 2-11.1(t) of the Miami-Dade County Code, as amended, a "Cone of Silence" is imposed upon each RFP or RFQ after advertisement and terminates at the time a written recommendation is issued. The Cone of Silence prohibits any communication regarding RFPs or RFQs between, among others:

- potential Proposers, service providers, lobbyists or consultants and the County's professional staff including, but not limited to, the County Mayor and the County Mayor's staff, County Commissioners or their respective staffs;
- the County Commissioners or their respective staffs and the County's professional staff including, but not limited to, the County Mayor and the County Mayor's staff; or
- potential Proposers, service providers, lobbyists or consultants, any member of the County's professional staff, the Mayor, County Commissioners or their respective staffs and any member of the respective selection committee.

The provisions do not apply to, among other communications:

- oral communications with the staff of the Vendor Assistance Unit, the responsible Procurement Agent or Contracting Officer, provided the communication is limited strictly to matters of process or procedure already contained in the solicitation document;
- oral communications at pre-proposal conferences, oral presentations before selection committees, contract negotiations during any duly noticed public meeting, public presentations made to the Board of County Commissioners during any duly noticed public meeting; or
- communications in writing at any time with any county employees, official or member of the Board of County Commissioners unless specifically prohibited by the applicable RFP or RFQ documents.

When the Cone of Silence is in effect, all potential vendors, service providers, bidders, lobbyists and consultants shall file a copy of any written correspondence concerning the particular RFP or RFQ with the Clerk of the Board, which shall be made available to any person upon request. The County shall respond in writing (if County deems a response necessary) and file a copy with the Clerk of the Board, which shall be made available to any person upon request. Written communications may be in the form of e-mail, with a copy to the Clerk of the Board at [clerkbcc@miamidade.gov](mailto:clerkbcc@miamidade.gov).

All requirements of the Cone of Silence policies are applicable to this Solicitation and must be adhered to. Any and all written communications regarding the Solicitation are to be submitted only to the Procurement Contracting Officer with a copy to the Clerk of the Board. The Cone of Silence shall not apply to oral communications at pre-proposal conferences, oral presentations before selection committees, contract negotiations during any duly noticed public meeting, public presentations made to the Board of County Commissioners during any duly noticed public meeting or communications in writing at any time with any county employee, official or member of the Board of County Commissioners unless specifically prohibited by the applicable RFP, RFQ or bid documents. The Proposer shall file a copy of any written communication with the Clerk of the Board. The Clerk of the Board shall make copies available to any person upon request.

### 1.5 Communication with Selection Committee Members

Proposers are hereby notified that direct communication, written or otherwise, to Selection Committee members or the Selection Committee as a whole are expressly prohibited. Any oral communications with Selection Committee members other than as provided in Section 2-11.1 of the Miami-Dade County Code are prohibited.

### 1.6 Public Entity Crimes

Pursuant to Paragraph 2(a) of Section 287.133, Florida Statutes, a person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a proposal for a contract to provide any goods or services to a public entity; may not submit a proposal on a contract with a public entity for the construction or repair of a public building or public work; may not submit proposals on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and, may not transact business with any public entity in excess of the threshold amount provided in Section 287.017 for Category Two for a period of thirty-six (36) months from the date of being placed on the convicted vendor list.

### 1.7 Lobbyist Contingency Fees

- a) In accordance with Section 2-11.1(s) of the Code of Miami-Dade County, after May, 16, 2003, no person may, in whole or in part, pay, give or agree to pay or give a contingency fee to another person. No person may, in whole or in part, receive or agree to receive a contingency fee.
- b) A contingency fee is a fee, bonus, commission or non-monetary benefit as compensation which is dependent on or in any way contingent upon the passage, defeat, or modification of: 1) any ordinance, resolution, action or decision of the County Commission; 2) any action, decision or recommendation of the County Mayor or any County board or committee; or 3) any action, decision or recommendation of any County personnel during the time period of the entire decision-making process regarding such action, decision or recommendation which foreseeably will be heard or reviewed by the County Commission or a County board or committee.

### 1.8 Collusion

In accordance with Section 2-8.1.1 of the Code of Miami-Dade County, where two (2) or more related parties, as defined herein, each submit a proposal for any contract, such proposals shall be presumed to be collusive. The foregoing presumption may be rebutted by the presentation of evidence as to the extent of ownership, control and management of such related parties in preparation and submittal of such proposals. Related parties shall mean Proposer or the principals thereof which have a direct or indirect ownership interest in another Proposer for the same contract or in which a parent company or the principals thereof of one Proposer have a direct or indirect ownership interest in another Proposer for the same contract. Proposals found to be collusive shall be rejected. Proposers who have been found to have engaged in collusion may be considered non-responsible, and may be suspended or debarred, and any contract resulting from collusive bidding may be terminated for default.

## 2.0 SCOPE OF SERVICES

### 2.1 Background

The County implemented a Self-Funded health program in August, 2007. AvMed, Inc. has served as the County's administrator since the inception of such Program. Currently, the County employs approximately 26,000 individuals in South Florida, although the Program covers 46,000 lives. Covered groups include Miami-Dade County active employees, retirees (Medicare and Non-Medicare Eligible), Consolidated Omnibus Budget Reconciliation Act (COBRA) participants and their eligible dependents, in addition to both the Housing Finance and Industrial Development Authorities (refer to the census data provided in **Attachment 1, Census**). Jackson Health System (JHS) had been a covered group within the County's Program since the inception of the current agreement, with the exception of Plan Year 2011. However, JHS will not participate as a covered group in the County's future Program, resulting from this Solicitation.

The County's existing Plan Design includes two (2) Point-of-Service (POS) (redesign and non-redesign) options, and four (4) Health Maintenance Organization (HMO) options: two (2) Open Access High (redesign and non-redesign), one (1) Select (narrow network redesign) and one (1) Low (non-redesign). Additionally, there are three (3) design options offered to Medicare-eligible (ages 65+) retirees, as follow: 1) Low HMO option with pharmacy, 2) High HMO with pharmacy, and 3) High HMO option with no pharmacy coverage. Design options and corresponding benefits are available for review at the County's Benefits Webpage. Please refer to the following link: <http://www.miamidade.gov/humanresources/benefits.asp> for further information. The County's newly introduced Select HMO option, which has a limited network, became effective on January 1, 2015. The Low HMO and non-redesign options may be eliminated

in the future. Notwithstanding, the County reserves the right to continue offering the Low HMO and non-redesign plan options to employees covered under certain bargaining units, based on their respective unit's agreement. Modifications to the County's benefit levels are subject to collective bargaining agreements. Additionally, the County reserves the right, at its sole discretion, to alter the current Plan Design going forward. The County is not interested in proposals that only offer one of the above design options described herein.

The majority of County employees are covered by a collective bargaining agreement. There are ten (10) labor organizations representing County employees, listed below as follows:

Labor Organizations:

- AFSCME 121 Water and Sewer Employees
- IAFF 1403 Fire Fighter Employees
- TWU Local 291 Transit Employees
- PBA Rank & File
- \*AFSCME 3292 Solid Waste Employees**
- \*AFSCME 1542 Aviation Employees**
- \*AFSCME 199 General Employees**
- \*GSAF Supervisory**
- \*GSAF Professional**
- PBA Law Enforcement Supervisory

\*Labor Organization which has adopted Program redesign options. Plan design options available to employees are based on negotiated bargaining unit agreements.

**Note:** The International Association of Firefighters Local 1403 ("IAFF"), offers a Union-sponsor medical plan to its members. Employees who are members of IAFF will be offered the opportunity to participate in the County's healthcare Program, or the Union-sponsored plan, if eligible. To identify employees participating in the Union-sponsored medical plan, Proposers may refer to the census data provided in **Attachment 1, Census**.

The County reserves the right to, at any time during the term of any agreement resulting from this Solicitation; allow either the JHS and/or IAFF group to participate in the County's Program. Both the JHS and IAFF group continue to participate in the County's existing dental and vision programs.

Additionally, the County anticipates continuing with the existing contribution strategy, per employee, as the current Self-Funded Employee Group Healthcare Program. The County contribution levels are subject to change, primarily based on collective bargaining agreements, and at the County's sole discretion.

## 2.2. Objective/Overall Goal of the County

The purpose of this Solicitation is to verify competitiveness of the County's current Program. The County is interested in receiving a comparative value-added Program design and fee, which may include, but not be limited to, reductions in employee out-of-pocket expenses, greater accessibility to network providers and a comparative formulary inclusive of the minimum therapeutic categories and copay tiers included in the current Plan design, along with specific options that address the County's actively employed and retired populations. Proposer's proposed Program should match, to the utmost extent possible, the County's existing Plan design. Please refer to the summary of benefits provided in **Attachment 2, Summary of Benefits Coverage (SOBC) Handbook**, for further information on existing Plan description.

In addition, the County is interested in the Proposer's approach to offering up to two (2) Additional Plan Option(s) for possible consideration and inclusion in the County's Program, at the County's sole discretion. Please refer to Section 2.11 for further information on Additional Plan Option(s).

## 2.3 Qualification Requirements

### A. Minimum Qualification Requirements

The Proposer shall:

1. Be licensed by the State of Florida, to transact the appropriate insurance, and/or administrative product and services, for which the proposal is being submitted for, as of the proposal due date.
2. Be financially stable to render the services listed herein, as of proposal due date. To satisfy this requirement, Proposer shall have a minimum "A- Rating" from A.M. Best Company, and no less than a "Classification of VII" or higher, as of the firm's most recent rating. If Proposer's rating does not meet rating requirement, the Proposer shall provide to the County: 1) its most recent independently audited financial statements with the auditor's notes for each of its past two (2) fiscal years, or 2) the U.S. Securities and Exchange Commission's (SEC) Annual 10-K Report for its past two (2) fiscal years.

**Note:** The above requirements are a continuing requisite throughout the contract award and term of the agreement.

**B. Preferred Qualifications**

The Proposer should:

1. Have been licensed to transact the appropriate insurance and/or administrative products for a minimum of five (5) years in the State of Florida. This preferred qualification is also applicable to the selected Proposer's sub-contractors.
2. Have a minimum of five (5) years of experience in the State of Florida administering claims and providing similar services to those listed in this Solicitation, for a governmental group of 10,000 employees or greater. This preferred qualification is also applicable to the selected Proposer's sub-contractors.
3. Have sufficient provider networks and quality providers in the areas in which County employees and retirees reside (primarily in South Florida). Retirees and out-of-area dependents should have sufficient access to providers and should be covered based on the same Plan Design as in-area participants. The minimum access standards are listed in Section 2.4 (12) (c). This preference is not applicable to the Wellness Program.

**2.4 General Information and Specifications**

1. **Attachment 3, Health Plan Premium Equivalent Rates**, outlines the 1) Monthly Active Employee Premium Equivalents Rates, 2) Monthly Pre-Medicare Retiree Rates, 3) Monthly Medicare Eligible Retiree Rates, 4) Dental and Vision rates, and 5) COBRA benefit rates for 2015. Employees' contributions are offered on a pre-tax basis, except for those employees with dependents who do not qualify as a tax dependent under the IRS provisions. The County reserves the right to change its contribution strategy at any time. Notwithstanding, the Proposer's fees and rates for the Program should remain in effect regardless of the County's contribution strategy.
2. New full-time employees are eligible for benefits coverage on the first day of the month following (or coincident with) 60 days of employment. Any part-time, non-temporary status employee, who consistently works at least 60 hours biweekly and has completed 60 continuous days of employment, is eligible for coverage. If an election is made, coverage is effective the first day of the month following completion of the eligibility period without any actively-at work exclusion. Eligibility for part-time employees is subject to change and will coincide with the eligibility for healthcare benefits for "variable hour" employees as defined by the Affordable Care Act.
3. Dependent eligibility is defined as follows:

Eligible Dependents	
Spouse*	Subscriber's legal spouse
Domestic Partner (DP)*	Subscriber's Domestic Partner in accordance with County Ordinance 08-61.
Child	Subscriber's biological child, legally adopted child or child placed in the home for the purpose of adoption in accordance with applicable state and federal laws.

Child with a Disability	Subscriber's Dependent child incapable of sustaining employment because of a mental or physical disability may continue coverage beyond the limiting age, if enrolled for medical prior to age 26 (or age 25 for dental). Proof of disability must be submitted to the Plan on an ongoing basis.
Step Child	Subscriber's spouse's child, for as long as Subscriber remains legally married to the child's parent.
Foster Child	A child that has been placed in Subscriber's home by the Department of Children and Families Foster Care Program or the foster care program of a licensed private agency. Foster children may be eligible until their age of maturity.
Legal Guardianship	A child (ward of Subscriber) for whom Subscriber has legal guardianship in accordance with an Order of Guardianship pursuant to applicable state and federal laws. Subscriber's ward may be eligible until their age of maturity.
Grandchild	A newborn dependent of Subscriber's covered child; coverage may remain in effect for up to 18 months of age as long as the newborn's parent remains covered. After 18 months, the grand child must have met the criteria of permanent legal ward of the Subscriber.
Over-Age Dependent**	Subscriber's unmarried dependent children and dependent children of Domestic Partner from ages 26 to age 30 (end of calendar year) are eligible for coverage. Over-age dependent must be without dependents, live in Florida or attend school in another state, and have no other health insurance.

**Coverage Limiting Age for Dependent Children** - Your dependent child's coverage ends on:

**Medical** - December 31 of the calendar year the child turns 26. Coverage may be continued to age 30. See below for adult children Eligibility Extended Medical Coverage.

**Dental & Vision** - December 31 of the calendar year child turns 25 (26 for vision). There is no extension for dental and vision coverage unless the adult child is disabled. For Plan Year 2016, the County may elect to extend coverage for both dental and vision until the child turns 26, at its sole discretion.

\*Subscriber's spouse or Domestic Partner (DP) is not an eligible dependent for coverage if also a County employee. Eligible employees are not permitted to cover each other on their group medical/dental plans. Ex-spouses may not be enrolled for group benefits under any circumstance, even if a divorce decree, settlement agreement or other document requires an employee to provide coverage for an ex-spouse.

\*\* Adult Children (FSS 627.6562) – Eligibility for Extended Medical Coverage

Medical coverage may be continued beyond December 31 of the year the adult child turns 26 until the end of the calendar year (December 31) the child turns age 30. Only medical coverage is available to this group. Once your dependent child reaches age 26, Subscriber is required to submit an **Affidavit of Eligibility** every year, with no exceptions, to continue such medical coverage for Over-Age Dependent. Failure to provide the documentation will result in ineligibility for coverage.

4. **Attachment 1, Census** also identifies all active employees that are eligible for stand-alone dental and/or vision options.
5. Employees under the age of 65, who retire from County service, may continue redesign POS, HMO or Select HMO Plan membership for themselves and their dependents until age 65 with remittance of the required premium to the County. Currently, the dependents of deceased retirees or retirees attaining Medicare eligibility may continue coverage through the retiree group Plan option by remitting the appropriate premiums to the County. The County reserves the right to make modifications, such as offering COBRA, as an alternative.
6. Retired employees who have attained age 65 may choose a plan for Medicare eligible retirees, offered by the County or a "Medicare-like" Advantage Plan offered by the selected Proposer with required premium remittance. The "Medicare-like" Advantage Plan premium (if any) will be collected directly by the selected Proposer.
7. Retiring employees should be provided a one-time opportunity, at the time of retirement (no later than 30 days from the retirement date), to change their medical insurance plan election in order to allow participation in the option which best meets their retirement needs. The selected Proposer should allow a separate annual enrollment change period for retirees, if requested by the County.

8. All retirees under and over the age of 65 should have access to national networks' at least equivalent to the networks offered to active employees.
9. All provisions should conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), where applicable. Please refer to the HIPAA Business Associate Agreement (BAA) included in the County's Form of Agreement herein provided as **Appendix C**. The selected Proposer is required to execute a BAA with the County as part of any award issued, resulting from this Solicitation.
  - (a) New employees and their eligible dependents are eligible for coverage without proof of insurability and are not subject to pre-existing condition exclusions.
  - (b) Employees who do not enroll within their initial benefits eligibility period, and do not satisfy a HIPAA special enrollment qualifying event, may not enroll until the following annual open enrollment period with a January 1 effective date.
  - (c) All employees and dependents enrolled as of December 31, 2015 are eligible for coverage with no actively at work exclusion.
10. The following rules apply for adding dependents:
  - (a) New Dependents - A dependent of an insured may be added to the Program by submitting an application within 45 days (60 days for newborns) of acquiring the dependent status. The employee must enroll the dependent within 45 days after the marriage, registration of Domestic Partnership or birth/adoption of a child (60 days for newborns). Coverage for a new spouse or Domestic Partner is effective the first day of the month following receipt of the application. Coverage for a newborn and children placed for adoption or adopted is effective as of the date of birth, or the earlier of 1) placement for adoption, or 2) adoption date. The change in rate, if applicable, is effective the first day of the month following the birth or the earlier of 1) placement for adoption or, 2) adoption date.
  - (b) If eligible employees have declined coverage for themselves or their dependents because of other insurance coverage and the other coverage ends, they may request enrollment within 45 days after the other coverage ends.
  - (c) Change of Family Status - A dependent may be added to, or deleted from, the Program at any time during the year, under HIPAA special enrollment, or pursuant to IRS Section 125 provisions, as adopted by the County. Proof of the change in family status must be submitted at the time of request for change. Please refer to item 10(a) above for information on adding a new dependent. Payroll changes to add a newborn are processed in accordance with Florida Statute 641.31(9). If the Change in Status (CIS) Form is received by the County within the first 31 days from birth, the rate is waived for the first 31 days. If the CIS Form is received after the first 31 days, but within 60 days of the birth, the new rate will be charged retroactive to the date of birth. The same applies when adding an adopted child or child placed for adoption. The rate is waived if the CIS Form is received by the County within the first 31 days from the earlier of: a) adoption, or b) placement for adoption. If the CIS Form is received after the first 31 days, but within 45 days of the event, the new rate will be charged retroactive to the earlier of: a) adoption or b) placement for adoption. Payroll changes to delete a dependent, other than those events specified in this paragraph, become effective the first day of the pay period following receipt by the County.
11. Employee membership terminates on the last day of the pay period for which applicable payroll deductions are made after the date the employee ceases active work for any reason other than an approved leave of absence or retirement.
12. The selected Proposer should:
  - (a) Adhere to generally accepted standards (as suggested by the National Committee for Quality Assurance "NCQA" or equivalent organization) for the consideration and credentialing of physicians in its networks.
  - (b) Notify the County of any change in its financial ratings by A.M. Best, or any significant change to selected Proposer's financial position and/or credit rating. Notification of such change should be provided to the County's Project Manager, no later than three (3) business days after the selected Proposer has been apprised of such change.

Notification to the County should include the submission of the selected Proposer's most recent independently audited financial statements for each of its past two (2) fiscal years, or the U.S. Securities and Exchange Commission's (SEC) Annual 10-K Report for its past two (2) years.

**Note:** After proposal submittal, the County reserves the right to require additional information from Proposers (or subcontractors) to determine financial capability (including, but not limited to, annual reviewed/audited statements with the auditor's notes for each of the past two (2) complete fiscal years).

- (c) Perform a GeoAccess analysis on an annual basis and make reasonable efforts to contract with additional physicians', hospital providers and urgent care centers where minimum access standards are not met. The minimum access standards are one (1) provider/facility within 5 miles, or two (2) providers/facilities within 10 miles.
- (d) Retain all fiduciary responsibilities, including, but not limited to responsibility for all internal and external appeals and determination of what constitutes a "Medical Necessity."

## 2.5 Enrollment/Communications Provisions

The selected Proposer should:

1. Provide promotional and enrollment materials at a minimum of thirty (30) days prior to the start of the County's annual open enrollment period, anticipated to be late October/early November for each upcoming Plan Year. Enrollment materials should be provided in printed format, in an adequate amount (for approximately 10,000 employees), at the County's discretion. The County may also require the selected Proposer to provide enrollment materials in alternate formats (i.e., Braille, different languages, large print and/or audio compact disk). An electronic version of enrollment materials, as well as a customized benefits website should be made available to all eligible employees/retirees during initial enrollment and to new enrollees. Materials include, but are not limited to, the Summary Plan Description (SPD) of Benefits and Coverage and other materials, as deemed necessary by the County. The costs of printing and producing materials, in all formats, are the sole responsibility of the selected Proposer.
2. Print, mail and electronically produce the SPD directly to Members' homes at least thirty (30) days prior to the start of the Plan Year, effective January 1<sup>st</sup>, at no additional cost to the County. The selected Proposer should provide additional supplies of the SPD to the County, as required by the County.
3. Utilize authorized County-specific forms and materials, as deemed necessary by the County.
4. Mail identification (ID) card to each enrolled Member within 5 business days from the date of receipt of each eligibility tape, excluding weekends and holidays. On-demand temporary ID card printing should be available at the selected Proposer's website, wherein Members can easily print temporary ID cards, when any of the following events occur:
  - a) Change in coverage option;
  - b) Change in coverage tier; and/or
  - c) A replacement/duplicate card is requested.
5. Ensure that Members/Subscribers can be identified by social security number, employee ID number **and** bargaining unit, as required by the County. The selected Proposer should ensure that all Social Security Numbers are maintained for all Members/Subscriber enrolled in the Program, and as such, should bear the responsibility of protecting the privacy and legal rights of all Members/Subscribers.
6. Distribute all communication materials to the various County locations no later than two (2) weeks prior to the start of the County's annual open enrollment period. The County should approve in writing all booklets and any/all other employee communications prior to its printing. Additionally, the County retains the right to prohibit distribution of any materials that make false or misleading statements, reference any Program other than the selected Proposer's Program, or any other materials or "giveaways", at the County's sole discretion, which the County deems to be inappropriate.
7. Review its Program-specific information to be included in the County's Employee Benefits Handbook for accuracy and provide the necessary updates to the County no later than September 1<sup>st</sup>, for each upcoming Plan Year. The County will

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- finalize and publish the Benefits Handbook. The County should retain final approval authority over all communication material.
8. Consent to the use of the County's existing Enrollment Form and/or on-line enrollment process. The Enrollment and Change in Status Forms can be found at the County's benefits website. The County uses web enrollment for the annual open enrollment and anticipates its continued use for ongoing enrollments.
  9. Have access to County employees on County premises, as determined by the County.
  10. Provide sufficient personnel to attend all initiating annual open enrollment period meetings with the County's Project Manager, and subsequent annual open enrollment period meetings (estimated to be approximately 30 on-site meetings). Such meetings schedule will be set by the County. The selected Proposer's personnel (i.e., Account Executive/Manager/Representative, etc.) should be available to attend periodic meetings throughout the Plan Year, scheduled by the County, with reasonable notice given.
  11. Consent to receiving eligibility data, in an electronic format, in the file layout used by the County.
  12. Update eligibility data within one (1) business day from the receipt of such data. The selected Proposer should notify the County of any issues arising within one (1) business day from the time of the data upload.
  13. Provide a single point of contact for the purpose of facilitating eligibility and enrollment information, and coordinating any internal distribution of such information, as well as facilitating any necessary transfer of data to third party administrators.

## 2.6 Benefit Provisions

The selected Proposer should:

1. Ensure that the Program complies with federal guidelines for Cafeteria Plans pursuant to IRS Code Section 125, as adopted by the County, the Patient Protection and Affordable Care Act (PPACA), the Age Discrimination in Employment Act (ADEA), American Disabilities Act (ADA), Medicare Secondary Payer, HIPAA, and COBRA, as well as any other applicable federal requirements and all Florida mandated benefits.
2. Offer full service provider contracts with Jackson Health Systems (JHS). JHS, as a provider, is subject to the Plan Design approved by the County and standard credentialing methods. The selected Proposer should allow Members to use all healthcare services (i.e., primary, secondary and tertiary services) offered by JHS. Provider contract between JHS and the selected Proposer should: a) become effective no later than December 1, 2015, b) remain in force for the duration of the selected Proposer's contract with the County, and any renewals or extensions thereof, and c) not contain any provision restricting or limiting a Member's use of these providers in any way that is not imposed on other physician or hospital provider within the selected Proposer's network. The selected Proposer should be prepared to offer proof of an existing contract or a properly executed letter of intent with JHS; or demonstrate to the County's satisfaction, at its sole discretion, the inability to contract with JHS was out of the selected Proposer's direct control or not its decision.
3. Accept the County's Employee Support Services Program (ESS) full authority to refer Members to the Program network for mental health/substance abuse services. The ESS may bill and be reimbursed by the selected Proposer according to negotiated fees. Refer to [http://www.miamidade.gov/assistance/employee\\_benefits.asp](http://www.miamidade.gov/assistance/employee_benefits.asp) for details regarding the ESS program.
4. Notify the County on a timely basis, of any issues/discussions surrounding its network of physicians and hospitals which would have an impact on County employees and retirees.
5. Provide the criteria for approval of organ transplants in the Program. This criterion should be defined and incorporated by reference into any agreement issued as a result of this Solicitation, including the criteria for approval and the definition of Experimental Procedures that will not be covered by the Program. The selected Proposer should provide all explanations in layperson's terms.

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6. Provide the criteria for approval of the Gastric Bypass Benefit Program at JHS and one additional hospital facility that is currently certified as a Bariatric Surgery Center of Excellence, as defined by the American College of Surgeons (ACS), or the American Board of Metabolic and Bariatric Surgeons (ABMBS). This criterion should be defined and incorporated by reference into any agreement issued as a result of this Solicitation, including the criteria for approval and the definition of Experimental Procedures that will not be covered by the Program. The selected Proposer should also provide all explanations in layperson's terms.
7. Provide the criteria and process for determining a "Medical Necessity" under the Program. This criteria and process should be defined and incorporated by reference into any agreement issued as a result of this Solicitation.
8. Accept pregnant employees/dependents', who are beyond the first trimester, continuance with their current attending OB/GYN, through the time of delivery (if not currently an in-network OB/GYN). Such coverage should be considered at the in-network level of benefits, with no balance billing to the Member.
9. Provide an in-network level of care and benefits to a designated employee, and/or retiree, in special catastrophic cases, as determined by the County (e.g., Amputation of any extremity, brain injury, burn injury requiring hospitalization, electrocution requiring hospitalization, heart attack, stroke, or coma, injury requiring hospital stay, Paraplegics/Quadriplegics, patient transportation by ambulance or life-flight, reflex sympathetic dystrophy syndrome (RSD), serious spinal cord injuries), even if the provider utilized is not part of the selected Proposer's network, with no balance billing.
10. Allow for any deductible satisfied, and credited by the selected Proposer for covered medical expenses in the last three months of a calendar year (every plan year) to be carried over to satisfy the participant's next year's deductible.
11. Offer the POS, HMOs and Select Network Plans on an open access basis with no Gatekeeper, excluding the HMO Low Option.
12. Provide full transparency on the pharmacy rebates earned based on the County's prescription drug utilization. The selected Proposer should provide credit to the County for such rebates on a quarterly basis. All earned rebates should be credited to the County even if the contract resulting from this Solicitation is terminated. The County reserves the right to audit the pharmacy benefits manager services inclusive of the rebate benefit, on an annual basis.
13. Notify the County within sixty (60) days of changes in the preferred drug list prior to the change, with an explanation of how it will directly affect the County's Members. The selected Proposer should include the number of Members affected and what other drug options the Members will have going forward. Positive additions are permitted at any time during the Plan Year, and with prior notification provided to the County. Deletions other than those resulting from Federal Drug Administration (FDA) requirements are only permissible one time per Plan Year, with a 60-day prior notification to the County.
14. Comply with the County's preference in receiving full transparency from the selected Proposer on provider discounts and billed charges and provider/facility contract terms.
15. Provide the County with full transparency on the Program's healthcare quality and pricing schematic, upon request by the County. Such transparency's intent is to allow the County to make decisions based on patterns and behaviors that drive costs and impact outcomes on premium prices, and coverage levels. The selected Proposer should serve as the County's strategic partner in forecasting possible reduction of risk and costs on common procedures to meet the needs of a changing economy. The County reserves the right to audit the Program for this information, on an annual basis.
16. Have a technology-enabled solution to support reduction in cost of care through a quality and appropriate delivery system. Such system's intent is to support value-based care by allowing providers, key accountable executives as designated by the County Mayor, and their staffs, access to critical clinical and financial information. The intent is also to enable timely, value-based health care decisions that accomplish better health outcomes, costs and improved patient/physician satisfaction, shifting focus from volume to value.

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## 2.7 Wellness and Disease Management Programs (Wellness Program)

The County is interested in a robust and sustainable wellness and disease management solution to help in addressing some of the critical issues that exist in the County's current healthcare Program, to include: costs, quality of services and the Member experience. The selected Proposer's proposed wellness and disease management programs should target local and regional market presence for delivering community-based healthcare and coordinated services. Selected Proposer should offer an integrated strategy to promote the overall health, wellness and productivity of Eligible Members while utilizing its experience with health plan administration. Selected Proposer may subcontract the wellness and disease management service programs. Please see Form B-1, Price Proposal/Financial Schedule for further clarification on the Wellness Program's fee submissions.

The Wellness Program's objective is to encourage healthier behaviors and measurable outcomes for all Eligible Members who agree to enroll in the Wellness Program. As Eligible Member(s) adopt and sustain behaviors that reduce health risks, improve quality of life, and enhance their personal effectiveness through the Wellness Program, they also drive a reduction in the County's healthcare costs/claims. Through highly effective offerings designed to identify, prevent and manage chronic conditions and other health factors, the selected Proposer should work towards improving the overall health of all Eligible Members. The selected Proposer should strategize and partner with the County in designing a Wellness Program tailored to the County's needs to include, at a minimum, the Wellness Program requirements below:

- Biometric Screening (Voluntary Basis)
- Flu Shot Administration Services – limited to interested employees at on-site location who have healthcare insurance
- Educational Seminars (e.g., Nutrition)
- Health Fair Coordination and Facilitation
- Onsite and Offsite benefit representatives
- Prescriptions for Healthy Living Program for diabetes, cholesterol, and high blood pressure medications

**Note:** AvMed currently provides the aforementioned wellness services as part of their ASO Fees.

### A. General Wellness Program Requirements

The selected Proposer should:

1. Provide for all enrolled Participants: 1) an annual Biometric Screening and Health Risk Assessment, 2) periodic health check-ins with a Health Coach, and 3) Wellness Risk-Targeting Programs, as described herein.
2. Perform all administrative functions for the Wellness Program including the monitoring and tracking of Participant compliance, producing all communication materials relating to the Wellness Program (including, but not limited to materials leading up to the launch of the Wellness Program), as well as ongoing communications to Participants. Selected Proposer should also provide monthly Wellness updates and results tracking milestones for informational purposes to designated County officials and labor organizations. Additionally, the selected Proposer should provide bi-monthly electronic data and trends for all Wellness Program Participants, to the County's Project Manager.
3. Secure and maintain any physical requirements for managing and providing the Wellness Program, including local office space and physical locations throughout the County, or as agreed to by the County. In order to maximize availability to the County Participants and remain cost-effective, the selected Proposer's facilities may be either on selected Proposer's owned/lease properties or housed at the County administration building and/or other County designated locations. County owned/leased properties may be made available for conducting Biometric Screenings at no cost to the selected Proposer (subject to prior approval by the County).
4. Provide one (1) health coach as a minimum, dedicated to rotating through all County locations that have Participants enrolled in the Wellness Program, for a minimum of 5 days per week. The selected Proposer should provide sufficient health coach(es) to support coverage to all County Participants. The selected Proposer should also provide computer terminals, printers and fax machines, etc. for its health coaches to: 1) readily have on-line access to Member eligibility information, 2) provide customer service related functions, and 3) assist in Program administration. The on-site health coach(es) should adhere to a business days/hours pursuant to the County's business schedule in order to be easily

accessible to employees. If an on-site health coach is on vacation, or otherwise absent for an extended period, a replacement health coach should be provided. Further, the County may request replacement of the on-site health coach(es) if he/she is not performing in a satisfactory manner, at the County's sole discretion. The County will advise the selected Proposer of any performance concerns and may allow for a resolution timeline, prior to requesting such replacement.

5. Ensure that selected Proposer's Wellness Program's Account Executive/Manager and management team should:
  - a. Devote the necessary time to manage the Wellness Program and be responsive to the County's needs pertaining to the Wellness Program, as defined herein. This includes being available for frequent telephone calls and on-site consultations with the County staff located in Miami, FL;
  - b. Provide the County with mobile phone numbers and email addresses of all key account management personnel;
  - c. Be thoroughly familiar with all of the functions that relate to the County's account; and,
  - d. Act on behalf of the County to effectively advance the County's action items through the selected Proposer's established approval structure.
6. Assume responsibility for all aspects of the Wellness Program compliance with HIPPA, GINA, ADA, ADEA, PDA, PPACA COBRA, and any other applicable laws and regulations.

#### **B. Enrollment**

1. Manage the Wellness Program enrollment process for all Eligible Members, as determined by the County to be eligible for participation. (Refer to census data provided in **Attachment 1, Census**).
2. Produce all enrollment documents and forms and process and manage the dissemination of these. The selected Proposer should include a process for reviewing and approving Eligible Member exemptions and claims data from the administrator to help identify potential Participants for the Wellness Programs, which will ensure compliance with all applicable federal and/or state laws or extraordinary life situations. Enrollment in the Wellness Program for the purpose of becoming a Participant, is not mandatory for Eligible Members.
3. Create a Wellness Program affirmation statement to be utilized in committing Eligible Members to becoming a Wellness Program Participant. By signing said affirmation, Eligible Member agrees to be an active Participant in all aspects of the Wellness Program. This affirmation should clearly define active engagement criteria and how Participant will comply with such criteria. Eligible Members not interested in enrolling in the Wellness Program should have the right to decline participation. Additionally, Wellness Program Participants may, at any time, cancel their participation.

#### **C. Health Risk Assessment (HRA)**

1. Coordinate and conduct an annual Health Risk Assessment (HRA) designed to identify existing and emerging health issues, and to provide a baseline for establishing a health improvement/maintenance plan electronically. Such Health Risk Assessment should consist of two components: a Health Questionnaire and Biometric Screening.
2. Implement Health Risk Assessments within 30 days of Plan Year effective date, or as agreed to by the County. In subsequent Plan Years, such assessment will be conducted during the first quarter of the Plan Year, or as agreed to by the County.
3. Create the Health Questionnaire and administer its dissemination and receipt to all Eligible Members. Such questionnaire should consist of posed inquiries which provide a basis for the assessment of health risks, identify tests to be administered in biometric screenings or other healthcare venues, areas of behavioral lifestyle changes necessary, and the identification of beneficial Wellness Risk-Targeting Programs. The questionnaire should contain sufficiently plain language for the ease of completion by Eligible Members without assistance from a medical professional. The questionnaire should also request multiple points of contact for each Eligible Member.
4. Provide employees and their eligible dependents with convenient access to, and options for, the submission of the health questionnaire, to include electronic submission.

5. Develop a biometric screening process consisting of cost-efficient health tests that can be administered by qualified individuals in locations convenient and accessible to Eligible Members. The biometric screening should supplement the Health Questionnaire in identifying health risks, areas of behavioral lifestyle changes and triggering actions which encourage Wellness Risk-Targeting Program participation, such as:
  - a. Provide and manage a system to schedule biometric screenings, with options to do so via a central Wellness website, and telephonically (which may consist of an Interactive Voice Response (IVR)). Selected Proposer should provide frequent reminders to schedule biometric screenings to facilitate Participant compliance.
  - b. At a minimum, the biometric screening should include tests to measure body fat (e.g. body mass index, waist measurement, or other method of body fat measurement) and blood pressure for all Members.
  - c. All Members should be encouraged to take lipid profile and/or A1C blood draw tests, including very strong encouragement for Members who demonstrated a need for these tests.
  - d. Additional testing as necessary to identify health risks that will be addressed by corresponding Wellness Risk-Targeting Program, supply scientific or empiric rationale, and a cost-benefit case for all additional tests and Risk-Targeting Programs.
6. Comply with the County guidelines concerning Eligible Member choice with respect to testing:
  - a. Eligible Member should not be required to take any given test to be considered compliant with the Wellness Program. Tests should be available to all Eligible Members, regardless of indicators from health questionnaire or other tests.
  - b. Wellness Program personnel administering Biometric Screenings should clearly explain to Eligible Members which tests are recommended for them based on clinical circumstances and strongly encourage and explain why it is not recommended that they undergo a given test when clinical circumstances indicate low or no value in them doing so. Notwithstanding, selected Proposer must provide the Eligible Member with the option of undergoing the test if they so choose to.
7. Maintain physical locations for biometric screenings (selected Proposer is responsible for all permits and regulatory compliance) which may include:
  - a. Selected Proposer locations throughout the County and temporary locations at County-owned properties (primarily central workplaces), but also including options to be discussed with the County (e.g. libraries, parks, etc.) and Union halls of participating unions.
  - b. Provide any necessary equipment (e.g., Kiosks, etc.) and/or facility modifications (e.g., partitions for privacy).
  - c. Ensure all physical locations are compliant with the ADA and other applicable regulations
  - d. Provide necessary privacy screens or other privacy protections for biometric screenings.
8. Ensure convenient access to the health questionnaire and biometric screening for all Eligible Members. Biometric screenings should also be available at convenient times during weekdays to allow County employees to undergo their biometric screening during allowed breaks and before or after work shifts that occur throughout the day. Biometric screenings should also be available outside of normal work hours, including evenings and/or weekends. Proposer is strongly advised to have arrangements with independent labs in order to accommodate Participants needs.
9. Complete the Health Risk Assessment for Eligible Member, including all Health Questionnaires and Biometric Screenings, within 100 days of the start of the Wellness Program, providing any necessary opportunities for missed assessment make-ups.
10. Develop a system in which Eligible Members may have recent test results (within six months prior to the start of the biometric screening date range) forwarded from their doctors in lieu of a Wellness Program provided biometric screening, if these were the same tests as the biometric screening the would have been performed.
11. Provide Health Risk Assessment results to Eligible Members in a timely manner through an initial Health Check-in, or other personalized results web-based sharing procedure. Results should:
  - a. Be supported by the results of the health questionnaire and all tests conducted in the biometric screening

- b. Identify potential individual health risks, and how to address them specifically through Wellness, including offering recommendations for their enrollment in Wellness Risk-Targeting Programs.
  - c. Multiple/high-touch methods of communication are encouraged for presentation of results (e.g. during first Health Check-in).
12. Provide Eligible Members paper or email output of their Health Risk Assessment results so that they may share with their physician or other healthcare professional, if they so desire.

#### **D. Health Check-Ins**

1. Perform telephonic and or face-to-face Health Check-Ins for the purpose of:
  - a. Discussing Participants' progress has made with respect to the major health issues identified in the annual Health Risk Assessment. Participants should have the ability to compare annual HRA's, year over year, to track improvements in health.
  - b. Reviewing the status of Risk-Targeting Program participation and engagement including strategies for maximum health impact.
  - c. Address any Wellness related questions that Participant may have regarding their health and recommend options to Participant seeking follow-up advice and care, as needed.
  - d. Motivate and encourage Participants to set health goals. Provide coaching on results tracking methods which may assist with reaching such goals as:
    - Lifestyle Changes
    - Wellness Education
    - Healthier Decision-Making
2. Establish and manage system to schedule Health Check-Ins, with options to do so via a central Wellness website or telephonically (which may consist of an IVR-based automated system or personal assistance). Participants should receive frequent reminders to schedule necessary Health Check-Ins to facilitate Participant compliance.
3. Initiate Participant Health Check-In by the health coach on the scheduled date and time specified. Check-in may last up to 30 minutes in length.
4. Provide alignment of Health Coaches with Participants for each Health Check-in to help foster trust between Participant and Health Coach.
5. Provide convenient times during week days for Health Check-Ins to allow County employees to perform their Check-in during allowed breaks and before or after work shifts that occur throughout the workday. Health Check-Ins should also be available during outside of normal work hours, including evenings and/or weekends.
6. Develop clear guidelines for the number and frequency of Health Check-Ins based on Participant's enrollment. Additional Health Check-Ins should not be required based on Participant health.
7. Provide health coach(es) with all applicable certifications and trainings as required by law, and as necessary to be effective advisors to Participants.
8. Provide Participant report to the County's Project Manager which incorporates the metrics from each of the above tasks and provides actionable information to improve health, in the aggregate.

#### **E. Wellness Risk-Targeting Programs**

1. Create and maintain a varied complement of Wellness Risk-Targeting Programs aimed at driving healthier behaviors and outcomes (or continuing healthy behavior) for Wellness Participants. Selected Proposer should provide education, challenges, outcome awareness, behavior tracking, and biometric measurement components. Risk-Targeting Programs should address common health risks for a broad spectrum of Participants' risk levels ranging from low-risk (e.g. weight maintenance, exercise optimization, etc.) to high-risk (e.g. obesity, smoker, etc.). Risk Targeting Programs may include, but are not limited to the following:

- a. Hypertension
- b. Hyperlipidemia
- c. General Fitness
- d. Significant sedentary risk
- e. Tobacco usage
- f. Diabetes and/or pre-diabetes
- g. Nutrition/Weight Management
- h. Other risks (e.g. asthma, stress, alcoholism, etc.)

Risk-Targeting Programs should be designed to drive significant health improvement/condition treatment, which will then lead to reduced future healthcare expenditures to the County. Risk-Targeting Programs must be sufficiently robust to drive health improvements, but still be reasonably convenient for Participants. This is a critical component to the Wellness Program's success.

2. The County's Wellness Program will be year round, with regularly occurring Risk-Targeting Programming. The expectation of the County is that Risk Targeting Programs will include regular reporting and tracking of program adherence and be conducted on a weekly basis or other such basis as long as the selected Proposer can demonstrate commensurate or improved effectiveness at driving improved health outcomes and lower costs.
3. Provide flexibility in all required Risk-Targeting Programs considering Participant vacation and holidays.
4. Allow Participants to select specific Risk-Targeting Programs for participation, without restrictions or limits other than those required by the Participant's health. The selected Proposer must generate strong recommendations for Participants as to the Risk-Targeting Programs in which they should consider enrolling based on risks, especially emerging chronic conditions or unsatisfactory chronic condition treatment, identified by the Health Risk Assessment, health questionnaire, biometric screening, or prior Risk-Targeting Program progress.
  - a. **Example 1:** A Participant demonstrating a risk for diabetes should be encouraged to enroll in a Risk-Targeting Program that may help mitigate their risk, but should not be required to enroll in any specific Risk-Targeting Program.
  - b. **Example 2:** A Participant who does not smoke should not be allowed to enroll in a tobacco cessation program specifically designed to mitigate smoking risk.
5. Update curricula as necessary to refresh Risk-Targeting Program materials and incorporate findings from County/selected Proposer quality control reviews of the Wellness Program results.
6. Manage Risk-Targeting Program enrollment process at initiation of Wellness and any subsequent Risk-Targeting Program selections by Participants. Wellness may impose reasonable limits upon the ability of Participants to switch Risk-Targeting Programs during the plan year.
7. Provide Participants with easy and convenient access to Risk-Targeting Programs by offering:
  - a. Various engagement methods for Participants such as, online, telephonically, health kiosks, etc.
  - b. Compliant common systems requirements. Any online programming must be easily accessible with standard computer programs and browsers.
  - c. All programming in English. Spanish is optional.

**Note:** Active participation in the Wellness Program's diabetes management program qualifies as participation in a weekly program – and no additional participation is necessary. Information about this program should be communicated via health check-ins to self-identified diabetics.

8. Provide periodic, optional Risk-Targeting classes for parents and/or families with children having childhood asthma or childhood diabetes.
9. Provide periodic, optional infant care educational classes for parents and/or families.

**F. Member Tracking**

1. Manage Eligible Member sign-up during the Wellness Program's enrollment period. Selected Proposer must maintain a master list of:
  - a. Enrolled Participants, and;
  - b. Any Eligible Member enrolled in the County's healthcare program which elects to not participate and/or opted-out of the Wellness Program.

2. Develop reasonable criteria for Active Engagement in each Wellness Program component:
  - a. Health Risk Assessment scheduling and attendance,
  - b. Health Check-Ins scheduling and follow-through,
  - c. Active participation in Risk-Targeting Programs.

Criteria should balance rigor of the Wellness Program with reasonable convenience for Participants, with specific attention to low impact engagement for healthy Participants. The goal of this criterion is to ensure active engagement and minimize non-active participation.

3. Identify critical component for compliance criteria is Active Engagement. Active Engagement cannot be defined in terms of attaining set targets in physical characteristics or behavior (e.g., target blood pressure, weight, food consumption, exercise goal attainment, etc.).
4. Include a process to acknowledge and track approved Participant short-and long-term absences from the Wellness Program (e.g., grievance period, sabbatical, medical leave, etc.), temporarily exempting Participants from the Wellness Program's Active Engagement criteria.
5. Track Participant compliance with Health Risk Assessment, Health Check-Ins, and Risk-Targeting Programs (through maintenance/updating of the master list).
6. Establish a system of warnings for Participants to alert them of instances of non-compliance. The system should be flexible and attempt to notify Participants via multiple means including phone, e-mail, or any other practical means. All warning notifications must produce a verifiable receipt and audit path.
7. Allow for a minimum of two separate non-compliance infractions and subsequent warnings without consequence. Non-compliance that results in expulsion from the Wellness Program will be determined at third infraction.
8. Identify communication method and define all Active Engagement compliance criteria, infractions, and warning system to be utilized in notifying Participants.
9. Facilitate the County's right to audit compliance process and resulting opt-outs annually. In the event the audit shows the compliance criteria was not adhered to, resulting in an understatement of Participant opt-outs, the Proposer will be obligated to reimburse the County for all overstated Participation payments.

**Note:** This audit will be conducted by a third party, if at any point, any private medical information or records are encountered.

10. Notify Participants of their removal from the Wellness Program due to their third infraction caused by their non-compliance with the Wellness Program requirements. The selected Proposer's notification should inform the Participant of the change in their status, along with any additional information deemed necessary by the selected Proposer.
11. Provide participation details to the County for any County-administered process for hearing disputes or appeals by Participants who feel they have been unduly declared non-compliant with the specified Active Engagement criteria. This process will occur monthly to make allowances for extraordinary life events on a verifiable, good faith basis. The selected Proposer's responsibilities will include providing details validating the decision to declare a Participant non-compliant (e.g. documentation of timing of when warnings were issued, Participant receipt of warnings, etc.). The selected

Proposer will also be expected to reinstate Participants who are deemed to have been unfairly removed from the Wellness Program. No appeal based on that necessity will be heard by County personnel.

#### **G. Launch of Wellness Program/Annual Enrollment**

1. Develop and design various brochures, pamphlets and materials, including any individual Participant waivers of liability (against the County) as may be required and as subject to the approval of the County's Project Manager. If such printed materials need to be mailed to Participants, then the selected Proposer must arrange to have the most cost efficient method and mechanisms in place to execute this task when required.
2. Provide presentation and informational materials to support the County's launch of Wellness (e.g., a "Know Your Numbers" campaign encouraging employees to know three key health metrics; BMI, blood pressure and cholesterol).

**Note:** The County anticipates approximately 50 rollout events after the announcement has been made, and before the Wellness Program is launched. Selected Proposer should provide sufficient material and staff as needed, at the County's sole discretion, to be utilized at said meetings for the benefit of County employees and labor union representatives.

3. Acknowledge that no contractual provisions, correspondence to the County or other document, should limit the selected Proposer's responsibility for the accuracy and completeness of these materials or for compliance with all laws, statutes and ordinances.
4. Develop and maintain a Wellness Program website specifically for the County that provides readily accessible and substantive information about the Wellness Program for Eligible Members seeking additional information.
5. Conduct a minimum of one training session for approximately 50 County benefit/human resource professional drawn from various departments, in preparation for the Wellness Program launch. Such training session(s) should serve as "train the trainer" events to fully prepare the Wellness Program's representatives and County personnel to answer common/anticipated questions during the enrollment period.

#### **H. Ongoing Reports**

1. Develop monthly informative and actionable communications highlighting the progress of the Wellness Program and indicating trends and utilization. Communications should summarize high-level macro trends including participation, program enrollment, and key behavior and biometric benchmarks. Provide identified performance data (which in form and substance protects the privacy of County employees) to the County once a quarter; such reports must conform to HIPAA requirements.
2. Produce monthly reports electronically in a file-format necessary to interface into a County-designated application which include, but are not limited to:
  - a. Complete Master List refresh update of current Participant population by unique identifier tag and work location, monthly, unless requested otherwise,
  - b. List of opt-out population, by unique identifier tag and work location,
  - c. Wellness Risk-Targeting Program enrollment population by Program type,
  - d. Active participation.
3. Tailor communications and presentations, as deemed necessary by the County, at its sole discretion, for the purpose of updating County officials. The selected Proposer should also develop a newsletter-type format for updates to Wellness Program Participants.
4. In the event the County enters into a separate agreement (with the selected Proposer or third party administrator at a future date) to integrate medical and pharmacy claims data through predictive modeling to develop risk profiles, selected Proposer should share data as required by law in an accessible format.

#### **I. Miscellaneous Communications**

1. To the extent permitted by law and only if directed by the County, selected Proposer should participate in a data exchange with any third party administrator authorized by the County, for purposes of Wellness Program analysis.

2. Provide telephone (advisory) and face-to-face service (on-site) to Participants for the purpose of answering questions about the Wellness Program, during reasonable hours.

#### J. Other Requirements

1. Advise and orient the County on the Wellness Program's initiatives and industry trends. The selected Proposer should be responsible for advising the County of all operational changes, industry specific litigation, practices and pending legislative changes that may affect coverage provided under the services during the term of the Agreement.
2. Provide all information that is necessary for the effective provision of the Wellness Program, including legal and administrative advice and assistance as needed.
3. Maintain confidentiality of County employees' records in compliance with all federal, state, and local regulations, in addition to maintaining other information deemed proprietary or confidential by the County or pursuant to applicable law. Any data provided by the County, employees or encountered by the selected Proposer during the performance of the services relating to any County employees, should be kept strictly confidential, and may not be sold, marketed, furnished or otherwise made available to any person or entity for any purpose.
4. Ensure that any Wellness Program participating providers are appropriately licensed, insured and of high quality and meet all other requirements specified by the selected Proposer.
5. Retain all records directly or indirectly related to its performance of services during the term of any contract and for a period of 5 years after termination or expiration of any contract, or until all pending disputes are resolved. The County has the right to review, abstract, audit and copy all records and accounts of the selected Proposer directly or indirectly related to any contracts with the County.
6. Ensure that in no case may services be offered except by persons and firms authorized and duly licensed as required by federal, state and/or local laws or regulations. The selected Proposer(s) must provide to the County's Project Manager annual evidence of all licenses and certifications, as may be necessary, to provide the Wellness Program's Scope of Services, as described herein.
7. Provide such services in conformance with applicable federal and state laws and regulations, County ordinances, personnel policies, procedures, rules and the terms of the applicable Wellness Program.

#### 2.8 Data and Reporting Provisions

The selected Proposer should:

1. Provide the following reports (which shall include the information as stated below):
  - (a) **Monthly Claims Activity Reports**  
Monthly report of billed and paid claims due to the County by the 15<sup>th</sup> of the following month, segregated by bargaining unit, active employees, Medicare and Non-Medicare eligible retirees, and further categorized with dependents and COBRA beneficiaries identified separately (active and retirees).
  - (b) **Annual Utilization Data Reports**  
Annual Utilization Data Report is due to the County within 90 days of the close of the Plan Year, showing in-patient utilization by hospital, outpatient utilization and physician by type of service.
  - (c) **Annual Care Management/Disease Management Reports**  
Annual Care and Disease Management Reports are due to the County within 30 days of the close of the Plan Year, showing utilization by Benefit Program (High Risk Stratification, Disease Specific, and Quality Management).

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**(d) Annual Prescription Drug Management Reports**

Annual Prescription Drug Management Report is due to the County within 30 days of the close of the Plan Year, providing cost indicators including brand and generic drug utilization, Formulary and non-Formulary utilization with separate specialty drug cost indicators.

**(e) Quarterly Data Feeds**

Quarterly Data Feeds are due to the County or its assigned consultant within 30 days of the close of the quarter, showing quarterly data feeds including all medical and pharmacy claims and covered membership.

**(f) Quarterly Quality and Performance Management Dashboards**

Quarterly Quality and Performance Management Dashboards showing a graphical presentation of the current status (snapshot) and historical trends of the County's key performance indicators to enable instantaneous and informed decisions to be made.

**(g) On-Demand Reports**

On-Demand Reports showing trends over time on advanced analytics to identify drivers of Plan quality, cost and utilization, as requested by the County. On-Demand Reports should be segregated by bargaining unit, active employees, Medicare and Non-Medicare eligible retirees, and COBRA further categorized with dependents and beneficiaries identified separately (active and retirees), as requested by the County.

On Demand Claims Data Report should be provided within 10 business days of the County's request. Such report should include, but not be limited to:

- a. paid claims data by month,
- b. incurred claims data by month,
- c. disruption and network data as requested,
- d. prescription drug and behavioral health care claims, and;
- e. large claims and utilization data as requested.

**(h) Quarterly Reports**

Quarterly Reports due to the County 30 days from the close of the quarter, showing Return on Investment (ROI) for the Wellness Program, and or any cost containment programs and Pharmacy rebate reconciliation.

2. Provide web-based access to eligibility, census data and individual claim information to the onsite customer service representatives for the County.
3. Maintain utilization statistics based on the resultant desired County Plan structure.
4. Provide to the County and its designated consultant, as applicable, with on-line access to the selected Proposer's reporting system in order to retrieve standard and ad hoc claims and utilization reports.

The County is ultimately interested in accessing/receiving all information through web-based reporting. The selected Proposer shall provide a timeline and data available to the County, for the implementation of such web-based reporting, within 90-days of contract effective date.

**2.9 Administrative and Related Services**

The selected Proposer should:

1. Consent to the County's self-billing process as all benefit plans should be administered on a self-billing fee/premium rate remittance basis.
2. Consent to bi-weekly bank wire-transfers of fee/premium payments, which will be remitted for the prior pay period. The selected Proposer should grant a 30 day grace period for active and paid leave status employees.

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3. Establish a benefit plan account ("Account") with a Qualified Public Depository bank agreed upon between the County and the selected Proposer. The account should be in the name of the County for the exclusive use of the County's plan. An initial imprest balance will be maintained in the Account. Should it become necessary to increase the imprest amount, the County will agree to do so based on satisfactory evidence, at the County's sole discretion, from the selected Proposer of insufficient funds. The Account shall be funded weekly by the County based on electronic reports provided by the selected Proposer of issued checks. The County will issue payments via wire transfer. Any interest earned in the Account should be accrued to the County and any banking fees will be charged to the Account.
4. Establish an account ("Disbursement Account") with a Qualified Public Depository bank for the purpose of disbursements. The Disbursement Account should be in the name of the selected Proposer. The selected Proposer, on behalf of the County, should issue payments from the Disbursement Account for Medical Plan benefits and Medical Plan-related expenses in the amount selected Proposer determines to be proper under the Medical Program and/or under and future agreement resulting from the Solicitation. The selected Proposer should provide to the County a monthly reconciliation of the Disbursement Account.
5. Implement the County's Group Health Care Benefit Program in a timely manner for a January 1, 2016 plan effective date, with enrollment scheduled for November of 2015, as deemed necessary by the County.
6. Pursue Coordination of Benefits (COB) before payment of claims. The selected Proposer should administer potential subrogation on a "pay, then pursue" basis. Subrogation action should not be pursued against the County for Workers' Compensation claims that have been denied by the County. Selected Proposer should annually identify all fees, percentage and to whom these fees are paid that are associated with such services but not limited to COB, subrogation, bill negotiations, etc. In addition, the selected Proposer should provide a quarterly report on claims that have been recovered, including the total amount, amount of recovery, fee/percentage and amount reimbursed to the County.
7. Coordinate directly with Medicare, on behalf of retirees, in processing Program claims for Medicare eligible retirees.
8. Administer appropriate procedures to carefully monitor and report the status of over-age unmarried dependent children and dependent children of Domestic Partner (26 years and over) to ensure satisfactory proof of eligibility is obtained and that coverage complies with Federal and State regulations, including COBRA status. Dependent children and dependent children of Domestic Partner losing group coverage due to age or loss of dependent status must be notified of their COBRA rights. The selected Proposer should notify the County within 60 days after the open enrollment effective date (January 1<sup>st</sup> of each year) of any discrepancies in eligibility including employee name, dependent to be deleted and any change in coverage level.
9. Provide all COBRA administration, including mailing of initial COBRA notification after receiving notification of a qualifying event from the County. The services required also include billing of beneficiaries and collection of appropriate premiums.
10. Verify dependent eligibility at initial enrollment and over age dependents and dependents with different last names at subsequent open enrollments, and notify the County within 60 days of any discrepancies in eligibility. The selected Proposer should verify eligibility for new hires and new enrollees within 30 days and notify the County of any discrepancies in eligibility.
11. Perform a bi-weekly reconciliation of accounts based on bi-weekly eligibility files (daily for retirees) provided by the County. The selected Proposer should notify the County in writing within 10 business days of any discrepancies, to include Member name, Member identification number, name of ineligible dependent and change in coverage level, if any.
12. Provide a local account representative (who shall be physically located in the Tri-County area, and be approved by the County) with full account management capabilities. The account representative should assist the County in the administration of the Plan approved by the County, in providing all necessary and related services for employees, in obtaining the appropriate resolution of issues including claims problems, and in any other way requested, related to the Services stated herein.
13. Ensure that selected Proposer's Account Executive/Manager and account management team should:

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- Devote the necessary time to manage the account and be responsive to County needs pertaining to this Scope of Services (this includes being available for frequent telephone calls and on-site consultations with the County staff located in Miami, FL.);
  - Provide the County with mobile phone numbers and email addresses of all key account management personnel;
  - Be thoroughly familiar with all of the proposing company's functions that relate to the County's account; and,
  - Act on behalf of the County to effectively advance County action items through the selected Proposer's corporate approval structure.
14. Provide four (4) dedicated on-site customer service representatives. On-site representatives will be housed at the County administration building and/or other County designated locations. The selected Proposer should provide computer terminals, printers and fax machines for its representatives that have on-line access capabilities of employees' eligibility and claims information, provide customer service related functions, and assist in plan administration. The on-site representatives should adhere to regular business days/hours pursuant to the County's business schedule in order to be easily accessible to employees. If an on-site representative is on vacation, or otherwise absent for an extended period, a replacement representative shall be provided. Further, the County may request replacement of the on-site representative if he/she is not performing in a satisfactory manner, at the County's sole discretion. The County will advise the selected Proposer of any performance concerns and allow adequate time to resolve before requesting such replacement.
  15. Provide an off-site dedicated member service team, based on one (1) dedicated member service team representative per 5,000 members enrolled in the Plan. The selected Proposer's designated member service team should receive training on the specifics of the County's Program, to be provided by the selected Proposer. There should also be a dedicated phone, fax number and webpage for County employees to access.
  16. Comply with the Performance Guarantee Standard Provisions (see **Attachment 4, Performance Guarantee Standard Provisions**, which provides an outline of the current standards). Compliance with Performance Guarantee Standard shall be measured annually at the end of each Plan Year and any non-compliance within each category should be assessed the amount at risk penalty, payable to the County.
  17. Ensure that the selected Proposer's claims processing system is fully integrated with its eligibility system, which continuously receives feeds from the County.
  18. Allow the County, or its representative in addition to the rights contained herein, the right to perform an annual audit of all medical and prescription claims, utilization management files, financial data and other information relevant to the County's account. The results of this independent audit will determine liquidated damages, in addition to recoveries, for failure to meet Performance Standards. The selected Proposer should maintain appropriate internal audit procedures for claims and customer service administration. Additional audit programs such as pre-disbursement audits, audits of selected providers, and audits of specific services are also desirable. Fraud prevention and detection procedures shall be maintained by the selected Proposer, including appropriate reporting to authorities.
  19. Allow the County or its representative access to review and audit physician, hospital, and pharmaceutical provider contracts, to include, but not limited to, the pricing and terms and conditions of such contracts.
  20. Provide all necessary data, reporting and reconciliation support as needed by the County for its participation in the Retiree Drug Subsidy ("RDS") Benefit Program under Medicare Part D. Such support will not include the preparation or submission of the actuarial attestation required for participation in the RDS Benefit Program. Selected Proposer should provide at no additional cost to the County, Medicare Part D prescription subsidy filing.
  21. Provide all necessary data, reporting and reconciliation support as needed by the County for its compliance with the Patient Protection and Affordable Care Act (PPACA), at no cost to the County.

## 2.10 Customer/Member Services

The selected Proposer should:

1. Communicate any significant changes in Member Services, (e.g., phone messages, prompts and personnel, etc.) to the County in advance of such changes taking place. The selected Proposer should receive the County's approval prior to implementing such changes to member service center and unit structure.
2. Provide the County with a dedicated (i.e., exclusive for Miami-Dade County) live Member Customer Service Team accessible via a toll-free telephone line. Such Team should receive training to be provided by the selected Proposer on the specifics of the County's Plan. There should also be a dedicated Interactive Voice Response phone number for County employees to access 24/7, 365 days a year.
3. Agree to the County's or the County's Benefits Consultant's, developed and administered customer satisfaction survey tools specific to the County's Plan. The County and the selected Proposer will work in unison to develop the survey. The survey should be conducted annually, at the County's discretion. All customer satisfaction tools must be approved by the County prior to execution. Results of the survey should be provided to the County with appropriate analysis and response by the selected Proposer.
4. Provide, within 30 days of the effective date of coverage, every new Member with a detailed explanation of the grievance procedures. Such notification should be provided to Members through the County's preferred method of delivery.

**Below Sections 2.11 and 2.12 are for informational purposes and will not be utilized for scoring purposes.**

### 2.11 Additional Plan Design(s)

As the County evolves its healthcare benefits strategy, the selected Proposer should be able to adapt to any future changes to the Self-Funded Employee Group Healthcare Program that will achieve efficiencies and cost savings to the County, such as the design and creation of Additional Plan Design(s). Proposers are highly encouraged to submit information for Additional Plan Design(s) as part of their proposal. The Additional Plan Design(s) should target cost savings for the County and its employees through a viable approach of additional plan designs and cafeteria type of plan election, such as Benefit Tiered HMO, high deductible plans, and limited networks, etc. Proposers providing for an Additional Plan Design(s) should consider the following criteria:

1. The plan designs should be outlined including plan summary for each benefit level. All state-mandated benefits must be covered and all exclusions, limitations and non-covered items should be fully described.
2. The network should have sufficient providers, to include all specialty levels and facilities.
3. Description of how cost savings can be achieved within the Additional Plan Design(s), including assumed enrollment within each offering.

The County will determine whether it is in its best interest to incorporate such additional plan design(s) in the future. In making such determination, the County will consider, among other things, whether savings for the referenced items can be achieved.

### 2.12 Additional Services

The County may also consider incorporating the opportunity to bundle dental, vision and ancillary benefits to the existing healthcare Program in the future. The County will determine whether it is in its best interest to incorporate such benefits in the future. In making such determination, the County will consider, among other things, whether savings for the referenced items can be achieved.

## 3.0 RESPONSE REQUIREMENTS

### 3.1 Submittal Requirements

In response to this Solicitation, Proposer should **complete and return the entire Proposal Submission Package**. Proposers should carefully follow the format and instructions outlined therein. All documents and information must be fully completed and signed as required and submitted in the manner described.

The proposal shall be written in sufficient detail to permit the County to conduct a meaningful evaluation of the proposed services. However, overly elaborate responses are not requested or desired.

## 4.0 EVALUATION PROCESS

**4.1 Review of Proposals for Responsiveness**

Each proposal will be reviewed to determine if the proposal is responsive to the submission requirements outlined in this Solicitation. A responsive proposal is one which follows the requirements of this Solicitation, includes all documentation, is submitted in the format outlined in this Solicitation, is of timely submission, and has the appropriate signatures as required on each document. Failure to comply with these requirements may result in the proposal being deemed non-responsive.

**4.2 Evaluation Criteria**

Proposals will be evaluated by an Evaluation/Selection Committee which will evaluate and rank proposals on criteria listed below. The Evaluation/Selection Committee will be comprised of appropriate County personnel and members of the community, as deemed necessary, with the appropriate experience and/or knowledge, striving to ensure that the Evaluation/Selection Committee is balanced with regard to both ethnicity and gender. The criteria are itemized with their respective weights for a maximum total of nine hundred thirty (930) points per Evaluation/Selection Committee member.

<b>A. <u>Technical Criteria (Administrative Services)</u></b>	<b><u>Points</u></b>
1. Proposer's relevant experience, qualifications, financial capability and past performance, to include relevant experience and qualifications of key personnel and key personnel of subcontractors, that will be assigned to this project, and experience and qualifications of subcontractors	100
2. Proposed Plan Design, Network, Disruption, Provider Reimbursement, Imaging Prescription Drug Benefits, and Wellness and Disease Management Programs	400
3. Member Services, Quality Assurance, Disaster Recovery, Utilization and Account Management, Reporting, Technology, Medical Management, Fraud and Abuse, and Implementation	200
<b>B. <u>Price Criteria</u></b>	
1. Proposer's proposed price/financial schedule for services	230

**4.3 Oral Presentations**

Upon completion of the technical criteria evaluation indicated above, rating and ranking, the Evaluation/Selection may choose to conduct an oral presentation with the Proposer(s) which the Evaluation/Selection Committee deems to warrant further consideration based on, among other considerations, scores in clusters and/or maintaining competition. (See Affidavit – "Lobbyist Registration for Oral Presentation" regarding registering speakers in the proposal for oral presentations.) Upon completion of the oral presentation(s), the Evaluation/Selection Committee will re-evaluate, re-rate and re-rank the proposals remaining in consideration based upon the written documents combined with the oral presentation.

**4.4 Selection Factor**

A Selection Factor is not applicable to this Solicitation.

**4.5 Local Certified Service-Disabled Veteran's Business Enterprise Preference**

This Solicitation includes a preference for Miami-Dade County Local Certified Service-Disabled Veteran Business Enterprises in accordance with Section 2-8.5.1 of the Code of Miami-Dade County. A VBE is entitled to receive an additional five percent (5%) of the total technical evaluation points on the technical portion of such Proposer's proposal. If a Miami-Dade County Certified Small Business Enterprise (SBE) measure is being applied to this Solicitation, a VBE which also qualifies for the SBE measure shall not receive the veteran's preference provided in this section and shall be limited to the applicable SBE preference.

#### 4.6 Price Evaluation

After the evaluation of the technical proposal, in light of the oral presentation(s) if necessary, the County will evaluate the price proposals of those Proposers remaining in consideration. Each Evaluation/Selection committee member will assign the points available, in combination with the technical proposal, based upon an evaluation of factors which may affect the ultimate cost to the County, including but not limited to the completeness of the proposal, the accuracy of the assumption underlying in the Proposer's price, the likelihood of any potential or stated contingencies that may affect the Solicitation. The price/financial evaluation is used as part of the evaluation process to determine the highest ranked Proposer. The County reserves the right to negotiate the final terms, conditions and pricing of the contract, as may be in the best interest of the County.

#### 4.7 Local Preference

The evaluation of competitive solicitations is subject to Section 2-8.5 of the Miami-Dade County Code, which, except where contrary to federal or state law, or any other funding source requirements, provides that preference be given to local businesses. If, following the completion of final rankings by the Evaluation/Selection Committee a non-local Proposer is the highest ranked responsive and responsible Proposer, and the ranking of a responsive and responsible local Proposer is within 5% of the ranking obtained by said non-local Proposer, then the Evaluation/Selection Committee will recommend that a contract be negotiated with said local Proposer.

#### 4.8 Negotiations

The Evaluation/Selection Committee will evaluate, score and rank proposals, and submit the results of their evaluation to the County Mayor or designee with their recommendation. The County Mayor or designee will determine with which Proposer(s) the County shall negotiate, if any, taking into consideration the Local Preference Section above. The County Mayor or designee, at their sole discretion, may direct negotiations with the highest ranked Proposer, negotiations with multiple Proposers, and/or may request best and final offers. In any event the County engages in negotiations with a single or multiple Proposers and/or requests best and final offers, the discussions may include price and conditions attendant to price.

Notwithstanding the foregoing, if the County and said Proposer(s) cannot reach agreement on a contract, the County reserves the right to terminate negotiations and may, at the County Mayor's or designee's discretion, begin negotiations with the next highest ranked Proposer(s). This process may continue until a contract acceptable to the County has been executed or all proposals are rejected. No Proposer shall have any rights against the County arising from such negotiations or termination thereof.

Any Proposer recommended for negotiations shall complete a Collusion Affidavit, in accordance with Sections 2-8.1.1 of the Miami-Dade County Code. (If a Proposer fails to submit the required Collusion Affidavit, said Proposer shall be ineligible for award.)

Any Proposer recommended for negotiations may be required to provide to the County its most recent certified business financial statements as of a date not earlier than the end of the Proposer's preceding official tax accounting period, together with a statement in writing, signed by a duly authorized representative, stating that the present financial condition is materially the same as that shown on the balance sheet and income statement submitted, or with an explanation for a material change in the financial condition. A copy of the most recent business income tax return will be accepted if certified financial statements are unavailable.

#### 4.9 Contract Award

Any contract, resulting from this Solicitation, will be submitted to the County Mayor or designee for approval. All Proposers will be notified in writing when the County Mayor or designee makes an award recommendation. The Contract award, if any, shall be made to the Proposer whose proposal shall be deemed by the County to be in the best interest of the County. Notwithstanding the rights of protest listed below, the County's decision of whether to make the award and to which Proposer shall be final.

#### 4.10 Rights of Protest

A recommendation for contract award or rejection of all proposals may be protested by a Proposer in accordance with the procedures contained in Sections 2-8.3 and 2-8.4 of the County Code, as amended, and as established in Implementing Order No. 3-21.

### 5.0 TERMS AND CONDITIONS

The anticipated form of agreement is attached. The terms and conditions summarized below are of special note and can be found in their entirety in the agreement:

**a) Vendor Registration**

Prior to being recommended for award, the Proposer shall complete a Miami-Dade County Vendor Registration Package. For online vendor registration, visit the Vendor Portal: <http://www.miamidade.gov/procurement/vendor-registration.asp>. Then, the recommended Proposer shall affirm that all information submitted with its Vendor Registration Package is current, complete and accurate at the time it submitted a response to the Solicitation by completing an Affirmation of Vendor Affidavit form as requested by the County.

**b) Insurance Requirements**

The Contractor shall furnish to the County, Internal Services Department, Procurement Management Services Division, prior to the commencement of any work under any agreement, Certificates of Insurance which indicate insurance coverage has been obtained that meets the stated requirements.

## 6.0 ATTACHMENTS

Draft Form of Agreement (to include Appendix C: HIPAA Business Associate Addendum)  
Proposal Submission Package

Attachment Package

Attachment 1:	Census
Attachment 2:	Summary of Benefits Coverage (SOBC) Handbook
Attachment 3:	Health Plan Premium Equivalent Rates
Attachment 4:	Performance Guarantee Standards Provisions
Attachment 5:	Plan Designs Worksheet
Attachment 6 a/b:	Utilization Report (Oct. 1, 2012 to Sept. 30, 2014)
Attachment 7 a/b:	Monthly Claims Activity Report (2013-2014)

Exhibit Package

Exhibit 1:	CPT Code Analysis
Exhibit 2:	Medical Claims Re-pricing Analysis
Exhibit 3:	Pharmacy Claims Re-pricing Analysis
Exhibit 4:	MAC List Sample
Exhibit 5:	Specialty Prescription Drug List Sample
Exhibit 6:	Top Utilized Physicians/Providers

*(This is the form of agreement the County anticipates awarding to the selected Proposer.)*

Self-Funded Employee Group Healthcare Program  
Contract No.

THIS AGREEMENT made and entered into as of this \_\_\_\_\_ day of \_\_\_\_\_ by and between \_\_\_\_\_, a corporation organized and existing under the laws of the State of \_\_\_\_\_, having its principal office at \_\_\_\_\_ (hereinafter referred to as the "Contractor"), and Miami-Dade County, a political subdivision of the State of Florida, having its principal office at 111 N.W. 1st Street, Miami, Florida 33128 (hereinafter referred to as the "County"),

WITNESSETH:

WHEREAS, the Contractor has offered to provide a Self-funded Employee Group Healthcare Program and associated administration services, on a non-exclusive basis, that shall conform to the Scope of Service (Appendix A); Miami-Dade County's Request for Proposals (RFP) No. 00196 and all associated addenda and attachments, incorporated herein by reference; and the requirements of this Agreement; and,

WHEREAS, the Contractor has submitted a written proposal dated \_\_\_\_\_, hereinafter referred to as the "Contractor's Proposal" which is incorporated herein by reference; and,

WHEREAS, the County desires to procure from the Contractor such Self-funded Employee Group Health Program and associated administrative services, for the County, in accordance with the terms and conditions of this Agreement;

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, the parties hereto agree as follows:

**ARTICLE 1. DEFINITIONS**

The following words and expressions used in this Agreement shall be construed as follows, except when it is clear from the context that another meaning is intended:

- a) The initials "ASO" to mean Administrative Services Only Fee. The ASO fee includes all services required under this Agreement, except for actual claims billed separately.
- b) The initials "AWP" to mean the Average Wholesale Price. This refers to the average price at which drugs are purchased at the wholesale level.
- c) The words "Cafeteria Plan" to mean a plan that offers flexible benefits under the Internal Revenue Code Section 125. Employees choose their benefits from a "menu" of cash and benefits, some of which can be paid with pretax deductions from wages.
- d) The words "Contract" or "Agreement" to mean collectively these terms and conditions, the Scope of Services (Appendix A), Price Schedule (Appendix B), Business Associate Addendum (Appendix C), Performance Guarantee Standards Provisions (Appendix D), all other appendices and attachments hereto, all amendments issued hereto, RFP No. 00196 and all associated addenda, and the Contractor's Proposal.
- e) The words "Contract Date" to mean the date on which this Agreement is effective.
- f) The words "Contract Manager" to mean Miami-Dade County's Director, Internal Services Department, or the duly authorized representative designated to manage the Contract.
- g) The word "Contractor" to mean \_\_\_\_\_ and its permitted successors and assigns.
- h) The word "Days" to mean Calendar Days.
- i) The word "Deliverables" to mean all documentation and any items of any nature submitted by the Contractor to the County's Project Manager for review and approval pursuant to the terms of this Agreement.
- j) The words "directed", "required", "permitted", "ordered", "designated", "selected", "prescribed" or words of like import to mean respectively, the direction, requirement, permission, order, designation, selection or prescription of the County's Project Manager; and similarly the words "approved", "acceptable", "satisfactory", "equal", "necessary", or words of like import to mean respectively, approved by, or acceptable or satisfactory to, equal or necessary in the opinion of the County's Project Manager.
- k) The words "Extra Work" or "Additional Work" to mean additions or deletions or modifications to the amount, type or value of the Work and Services as required in this Contract, as directed and/or approved by the County.
- l) The word "Formulary" to mean a list of covered pharmaceuticals.
- m) The word "Gatekeeper" to mean a caretaker who is responsible for the administration of the patient's treatment. The Gatekeeper coordinates and authorizes all medical services, laboratory studies, specialty referrals and hospitalizations.
- n) The initials "HMO" to mean Health Maintenance Organization.

- o) The words "Medical Necessity" to mean accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.
- p) The word "Member" to mean all employees, retirees, and their dependents enrolled in Medical Program.
- q) The words "Narrow, Tailored and High Performance Networks" are all terms used to describe similar types of benefit plans which have costs substantially lower than traditional open access HMOs or standard PPO/POS offerings.
- r) The words "Open Access HMO" to mean an HMO plan that only allows members to receive treatment within the HMO (health maintenance organization) network. Additionally, members can visit a specialist without first obtaining a referral from their primary doctor. HMO Open Access plans still restrict you to the network, but give you freedom to visit specialists without a referral.
- s) The word "On-site" to mean location where County provides office space for the Contractor's staff, currently at 111 NW 1<sup>st</sup> Street, Miami Dade, Florida, 33128.
- t) The initials "PEPM" to mean per employee, per month.
- u) The words "Plan Year" to mean calendar year, January 1 through December 31.
- v) The initials "POS" to mean Point-of- Service.
- w) The word "Provider" to mean medical/pharmaceutical professional rendering services under the Program.
- x) The words "Project Manager" to mean the County Mayor or the duly authorized representative designated to manage the Project.
- y) The words "Scope of Services" to mean the document appended hereto as Appendix A, which details the work to be performed by the Contractor.
- z) The words "Self-funded Program" to mean a program offered by employers who directly assume the risk.
- aa) The word "subcontractor" or "subconsultant" to mean any person, entity, firm or corporation, other than the employees of the Contractor, who furnishes labor and/or materials, in connection with the Work, whether directly or indirectly, on behalf and/or under the direction of the Contractor and whether or not in privity of Contract with the Contractor.
- bb) The word "Subscriber" to mean person whose employment makes them eligible for group health insurance benefits.
- cc) The words "Work", "Services" "Program", or "Project" to mean all matters and things required to be done by the Contractor in accordance with the provisions of this Contract.

**ARTICLE 2. ORDER OF PRECEDENCE**

If there is a conflict between or among the provisions of this Agreement, the order of precedence is as follows: 1) these terms and conditions, 2) the Scope of Services (Appendix A), and Price Schedule (Appendix B), 3) Business Associate Agreement (Appendix C), 4) Performance Guarantee Standard Provisions (Appendix D), the Miami-Dade County's RFP No. 00196 and any associated addenda and attachments thereof.

**ARTICLE 3. RULES OF INTERPRETATION**

- a) References to a specified Article, section or schedule shall be construed as reference to that specified Article, or section of, or schedule to this Agreement unless otherwise indicated.
- b) Reference to any agreement or other instrument shall be deemed to include such agreement or other instrument as such agreement or other instrument may, from time to time, be modified, amended, supplemented, or restated in accordance with its terms.
- c) The terms "hereof", "herein", "hereinafter", "hereby", "herewith", "hereto", and "hereunder" shall be deemed to refer to this Agreement.
- d) The titles, headings, captions and arrangements used in these Terms and Conditions are for convenience only and shall not be deemed to limit, amplify or modify the terms of this Contract, nor affect the meaning thereof.

**ARTICLE 4. NATURE OF THE AGREEMENT**

- a) This Agreement incorporates and includes all prior negotiations, correspondence, conversations, agreements, and understandings applicable to the matters contained in this Agreement. The parties agree that there are no commitments, agreements, or understandings concerning the subject matter of this Agreement that are not contained in this Agreement, and that this Agreement contains the entire agreement between the parties as to all matters contained herein. Accordingly, it is agreed that no deviation from the terms hereof shall be predicated upon any prior representations or agreements, whether oral or written. It is further agreed that any oral representations or modifications concerning this Agreement shall be of no force or effect, and that this Agreement may be modified, altered or amended only by a written amendment duly executed by both parties hereto or their authorized representatives.
- b) The Contractor shall provide the services set forth in the Scope of Services, and render full and prompt cooperation with the County in all aspects of the Services performed hereunder.
- c) The Contractor acknowledges that this Agreement requires the performance of all things necessary for or incidental to the effective and complete performance of all Work and Services under this Contract. All things not expressly mentioned in this Agreement but necessary to carrying out its intent are required by this Agreement, and the Contractor shall perform the same as though they were specifically mentioned, described and delineated.
- d) The Contractor shall furnish all labor, materials, tools, supplies, and other items required to perform the Work and Services that are necessary for the completion of this Contract.

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All Work and Services shall be accomplished at the direction of and to the satisfaction of the County's Project Manager.

- e) The Contractor acknowledges that the County shall be responsible for making all policy decisions regarding the Scope of Services. The Contractor agrees to provide input on policy issues in the form of recommendations. The Contractor agrees to implement any and all changes in providing Services hereunder as a result of a policy change implemented by the County. The Contractor agrees to act in an expeditious and fiscally sound manner in providing the County with input regarding the time and cost to implement said changes and in executing the activities required to implement said changes.

**ARTICLE 5. CONTRACT TERM**

The Contract shall become effective on the date stipulated on the first page herein and shall continue until December 31, 2020. The County, at its sole discretion, reserves the right to exercise the option to renew this Contract for a twenty-four (24) month optional renewal period. The effective date of the Self-funded Employee Group Healthcare Program shall begin at 12:01 a.m. on January 1, 2016. This Contract may be extended beyond the renewal period by mutual agreement between the County and the Contractor, upon approval by the Board of County Commissioners.

**ARTICLE 6. NOTICE REQUIREMENTS**

All notices required or permitted under this Agreement shall be in writing and shall be deemed sufficiently served if delivered by Registered or Certified Mail, with return receipt requested; or delivered personally; or delivered via fax or e-mail (if provided below) and followed with delivery of hard copy; and in any case addressed as follows:

**(1) to the County**

- a) to the Project Manager:

Miami-Dade County  
Human Resources Department  
Attention: Human Resources Department Director  
111 N. W. 1<sup>st</sup> Floor, Suite 2110  
Miami, FL 33128-1989  
Phone: 305-375-1589  
Email: Arleene.cuellar@miamidade.gov  
With a copy to: hcarter@miamidade.gov

and,

- b) to the Contract Manager:

Miami-Dade County  
Internal Services Department, Procurement Management Services Division  
111 N.W. 1<sup>st</sup> Street, Suite 1375  
Miami, FL 33128-1974

Attention: Senior Assistant Director  
Phone: (305) 375-2363  
Fax: (305) 375-2316  
E-mail: Singer@miamidade.gov

**(2) To the Contractor**

Attention:  
Phone:  
Fax:  
E-mail:

Either party may at any time designate a different address and/or contact person by giving notice as provided above to the other party. Such notices shall be deemed given upon receipt by the addressee.

**ARTICLE 7. PAYMENT FOR SERVICES, FUNDING AND PAYMENT OF CLAIMS**

- a. The Contractor warrants that it has reviewed the County's requirements and has asked such questions and conducted such other inquiries as the Contractor deemed necessary in order to determine the price the Contractor will charge to provide the Work and Services to be performed under this Contract. The compensation for all Work and Services performed under this Contract, including all costs associated with such Work and Services, shall be in accordance with Appendix B, Price Schedule. The County shall have no obligation to pay the Contractor any additional sum in excess of this amount, except for a change and/or modification to the Contract, which is approved and executed in writing by the County and the Contractor.
- b. All Services undertaken by the Contractor before County's approval of this Contract shall be at the Contractor's risk and expense.
- c. The Contractor shall establish a benefit plan account ("Account") with a Qualified Public Depository bank agreed upon between County and the Contractor. The account shall be in the name of the County for the exclusive use of the County's plan. An initial imprest balance will be maintained in the Account. Should it become necessary to increase the imprest amount, the County will agree to do so based on satisfactory evidence, at the County's sole discretion, from the Contractor of insufficient funds. The Account shall be funded weekly by the County based on electronic reports provided by the Contractor of issued checks. The County will issued payments via wire transfer. Any interest earned in the Account shall be accrued to the County and any banking fees will be charged to the Account.
- d. The Contractor shall establish an account ("Disbursement Account") with a Qualified Public Depository bank for the purpose of disbursements. The Disbursement Account shall be in the name of the Contractor. The Contractor, on behalf of the County, shall issue payments from the Disbursement Account for healthcare Plan benefits and Plan-related expenses in the amount Contractor determines to be proper under the healthcare Program and/or under

this Agreement. The Contractor shall provide to the County a monthly reconciliation of the Disbursement Account.

- e. In the event that sufficient funds are not available in the Account to pay all healthcare Plan benefits and Plan-related expenses when due, then Contractor shall notify the County accordingly.
- f. In the event Contractor pays any person less than the amount to which they are entitled under the Self-Funded Employee Group Healthcare Program, Contractor will promptly adjust the underpayment by drawing the additional funds from the County's Account. In the event Contractor overpays any person entitled to benefits under the Self-Funded Employee Group Healthcare Program, or pays benefits to any person not entitled to them, Contractor shall take all reasonable steps to recover the overpayment and credit the Account accordingly; however, Contractor shall not be required to initiate court proceedings to recover an overpayment. Contractor shall be liable for overpayments except to the extent that said overpayment resulted from acts or omissions of the County, its officers, directors, or employees.
- g. Contractor shall indemnify and save the County harmless from any loss proximately caused by criminal or intentionally wrongful acts by any employee of Contractor arising out of its use of the Account. This indemnity shall survive the termination of this Agreement. The County shall give Contractor prompt and timely notice of any fact or condition which comes to its attention which may give rise to a claim of indemnity under this paragraph.
- h. Following termination of this Agreement, the County shall remain liable for payment of all Plan benefits or fees due any provider or entity for services rendered prior to termination. County shall reimburse Contractor to the extent Contractor makes any such payment. In no event shall any payment of healthcare Plan benefits or fees by Contractor be construed to oblige Contractor to assume any liability of the County for the payment of such benefits or fees. This provision shall survive the termination of this Agreement.

**ARTICLE 8. PRICING**

Prices for the Administrative Services Only (ASO) Fee shall be in accordance with Appendix B – Price/Financial Schedule. However, the Contractor may offer incentive discounts to the County at any time during the Contract term, including any renewal or extension thereof.

**ARTICLE 9. METHOD AND TIMES OF PAYMENT**

The County will remit applicable Administrative Fees or Premiums to the Contractor on a bi-weekly basis for the prior pay period, accompanied by an electronic file of employee salary deductions after the County either deducts the employee contributions through its payroll process or receives payment from employees on an unpaid leave of absence. The County retains the right, at all times, to self-bill. The County will remit Administrative Fees or Premium payments based on its records.

**ARTICLE 10. INDEMNIFICATION AND INSURANCE**

The Contractor shall indemnify and hold harmless the County and its officers, employees, agents and instrumentalities from any and all liability, losses or damages, including attorneys'

fees and costs of defense, which the County or its officers, employees, agents or instrumentalities may incur as a result of claims, demands, suits, causes of actions or proceedings of any kind or nature arising out of, relating to or resulting from the performance of this Agreement by the Contractor or its employees, agents, servants, partners principals or subcontractors. The Contractor shall pay all claims and losses in connection therewith and shall investigate and defend all claims, suits or actions of any kind or nature in the name of the County, where applicable, including appellate proceedings, and shall pay all costs, judgments, and attorney's fees which may issue thereon. The Contractor expressly understands and agrees that any insurance protection required by this Agreement or otherwise provided by the Contractor shall in no way limit the responsibility to indemnify, keep and save harmless and defend the County or its officers, employees, agents and instrumentalities as herein provided.

Upon County's notification, the Contractor shall furnish to the Internal Services Department, Procurement Management Division, Certificates of Insurance that indicate that insurance coverage has been obtained, which meets the requirements as outlined below:

1. Worker's Compensation Insurance for all employees of the Contractor as required by Florida Statute 440.
2. Commercial General Liability Insurance on a comprehensive basis in an amount not less than \$300,000 combined single limit per occurrence for bodily injury and property damage. **Miami-Dade County must be shown as an additional insured with respect to this coverage.**
3. Automobile Liability Insurance covering all owned, non-owned, and hired vehicles used in connection with the Services, in an amount not less than \$300,000 combined single limit per occurrence for bodily injury and property damage.
4. Professional Liability Insurance in an amount not less than \$3,000,000 per claim.

The company must be rated no less than "A-" as to management, and no less than "Class VII" as to financial strength by A.M. Best Company, Oldwick, New Jersey, or its equivalent, subject to the approval of the County Risk Management Division.

OR

The company must hold a valid Florida Certificate of Authority as shown in the latest "List of All Insurance Companies Authorized or Approved to Do Business in Florida", issued by the State of Florida Department of Financial Services and are members of the Florida Guaranty Fund.

**The mailing address of Miami-Dade County as the certificate holder must appear on the certificate of insurance as follows:**

**Miami-Dade County  
111 N.W. 1st Street  
Suite 1300  
Miami, Florida 33128-1974**

Compliance with the foregoing requirements shall not relieve the Contractor of this liability and obligation under this section or under any other section in this Agreement.

Award of this Contract is contingent upon the receipt of the insurance documents, as required,

within ten (10) business days. If the insurance certificate is received within the specified timeframe but not in the manner prescribed in this Agreement, the Contractor shall have an additional five (5) business days to submit a corrected certificate to the County. If the Contractor fails to submit the required insurance documents in the manner prescribed in this Agreement within fifteen (15) business days, the Contractor shall be in default of the contractual terms and conditions and award of the Contract may be rescinded, unless such timeframe for submission has been extended by the County.

The Contractor shall be responsible for ensuring that the insurance certificates required in conjunction with this Section remain in force for the duration of the contractual period of the Contract, including any and all option years or extension periods that may be granted by the County. If insurance certificates are scheduled to expire during the contractual period, the Contractor shall be responsible for submitting new or renewed insurance certificates to the County at a minimum of thirty (30) calendar days in advance of such expiration. In the event that expired certificates are not replaced with new or renewed certificates which cover the contractual period, the County shall suspend the Contract until such time as the new or renewed certificates are received by the County in the manner prescribed herein; provided, however, that this suspended period does not exceed thirty (30) calendar days. Thereafter, the County may, at its sole discretion, terminate this contract.

**ARTICLE 11. MANNER OF PERFORMANCE**

- a) The Contractor shall provide the Services described herein in a competent and professional manner satisfactory to the County in accordance with the terms and conditions of this Agreement. The County shall be entitled to a satisfactory performance of all Services described herein and to full and prompt cooperation by the Contractor in all aspects of the Services. At the request of the County, the Contractor shall promptly remove from the project any Contractor's employee, subcontractor, or any other person performing Services hereunder. The Contractor agrees that such removal of any of its employees does not require the termination or demotion of any employee by the Contractor.
- b) The Contractor agrees to defend, hold harmless and indemnify the County and shall be liable and responsible for any and all claims, suits, actions, damages and costs (including attorney's fees and court costs) made against the County, occurring on account of, arising from or in connection with the removal and replacement of any Contractor's personnel performing services hereunder at the behest of the County. Removal and replacement of any Contractor's personnel as used in this Article shall not require the termination and or demotion of such Contractor's personnel.
- c) The Contractor agrees that at all times it will employ, maintain and assign to the performance of the Services a sufficient number of competent and qualified professionals and other personnel to meet the requirements to which reference is hereinafter made. The Contractor agrees to adjust its personnel staffing levels or to replace any its personnel if so directed upon reasonable request from the County, should the County make a determination, in its sole discretion, that said personnel staffing is inappropriate or that any individual is not performing in a manner consistent with the requirements for such a position.
- d) The Contractor warrants and represents that its personnel have the proper skill, training, background, knowledge, experience, rights, authorizations, integrity, character and licenses as necessary to perform the Services described herein, in a competent and

professional manner.

- e) The Contractor shall at all times cooperate with the County and coordinate its respective work efforts to most effectively and efficiently maintain the progress in performing the Services.
- f) The Contractor shall comply with all provisions of all federal, state and local laws, statutes, ordinances, and regulations that are applicable to the performance of this Agreement.

**ARTICLE 12. EMPLOYEES OF THE CONTRACTOR**

All employees of the Contractor shall be considered to be, at all times, employees of the Contractor under its sole direction and not employees or agents of the County. The Contractor shall supply competent employees. Miami-Dade County may require the Contractor to remove an employee it deems careless, incompetent, insubordinate or otherwise objectionable and whose continued employment on County property is not in the best interest of the County. Each employee shall have and wear proper identification.

**ARTICLE 13. INDEPENDENT CONTRACTOR RELATIONSHIP**

The Contractor is, and shall be, in the performance of all work services and activities under this Agreement, an independent contractor, and not an employee, agent or servant of the County. All persons engaged in any of the work or services performed pursuant to this Agreement shall at all times, and in all places, be subject to the Contractor's sole direction, supervision and control. The Contractor shall exercise control over the means and manner in which it and its employees perform the work, and in all respects the Contractor's relationship and the relationship of its employees to the County shall be that of an independent contractor and not as employees and agents of the County.

The Contractor does not have the power or authority to bind the County in any promise, agreement or representation other than specifically provided for in this Agreement.

**ARTICLE 14. AUTHORITY OF THE COUNTY'S PROJECT MANAGER**

- a) The Contractor hereby acknowledges that the County's Project Manager will determine in the first instance all questions of any nature whatsoever arising out of, under, or in connection with, or in any way related to or on account of, this Agreement including without limitations: questions as to the value, acceptability and fitness of the Services; questions as to either party's fulfillment of its obligations under the Contract; negligence, fraud or misrepresentation before or subsequent to acceptance of the Contractor's Proposal; questions as to the interpretation of the Scope of Services; and claims for damages, compensation and losses.
- b) The Contractor shall be bound by all determinations or orders and shall promptly comply with every order of the Project Manager, including the withdrawal or modification of any previous order and regardless of whether the Contractor agrees with the Project Manager's determination or order. Where orders are given orally, they will be issued in writing by the Project Manager as soon thereafter as is practicable.
- c) The Contractor must, in the final instance, seek to resolve every difference concerning

the Agreement with the Project Manager. In the event that the Contractor and the Project Manager are unable to resolve their difference, the Contractor may initiate a dispute in accordance with the procedures set forth in this Article. Exhaustion of these procedures shall be a condition precedent to any lawsuit permitted hereunder.

- d) In the event of such dispute, the parties to this Agreement authorize the County Mayor or designee, who may not be the Project Manager or anyone associated with this Project, acting personally, to decide all questions arising out of, under, or in connection with, or in any way related to or on account of the Agreement (including but not limited to claims in the nature of breach of contract, fraud or misrepresentation arising either before or subsequent to execution hereof) and the decision of each with respect to matters within the County Mayor's purview as set forth above shall be conclusive, final and binding on parties. Any such dispute shall be brought, if at all, before the County Mayor within 10 days of the occurrence, event or act out of which the dispute arises.
- e) The County Mayor may base this decision on such assistance as may be desirable, including advice of experts, but in any event shall base the decision on an independent and objective determination of whether Contractor's performance or any Deliverable meets the requirements of this Agreement and any specifications with respect thereto set forth herein. The effect of any decision shall not be impaired or waived by any negotiations or settlements or offers made in connection with the dispute, whether or not the County Mayor participated therein, or by any prior decision of others, which prior decision shall be deemed subject to review, or by any termination or cancellation of the Agreement. All such disputes shall be submitted in writing by the Contractor to the County Mayor for a decision, together with all evidence and other pertinent information in regard to such questions, in order that a fair and impartial decision may be made. Whenever the County Mayor is entitled to exercise discretion or judgment or to make a determination or form an opinion pursuant to the provisions of this Article, such action shall be fair and impartial when exercised or taken. The County Mayor, as appropriate, shall render a decision in writing and deliver a copy of the same to the Contractor. Except as such remedies may be limited or waived elsewhere in the Agreement, Contractor reserves the right to pursue any remedies available under law after exhausting the provisions of this Article.

#### **ARTICLE 15. MUTUAL OBLIGATIONS**

- a) This Agreement, including attachments and appendices to the Agreement, shall constitute the entire Agreement between the parties with respect hereto and supersedes all previous communications and representations or agreements, whether written or oral, with respect to the subject matter hereto unless acknowledged in writing by the duly authorized representatives of both parties.
- b) Nothing in this Agreement shall be construed for the benefit, intended or otherwise, of any third party that is not a parent or subsidiary of a party or otherwise related (by virtue of ownership control or statutory control) to a party.
- c) In those situations where this Agreement imposes an indemnity obligation on the Contractor, the County may, at its expense, elect to participate in the defense if the County should so choose. Furthermore, the County may at its own expense defend or settle any such claims if the Contractor fails to diligently defend such claims, and thereafter seek indemnity for costs from the Contractor.

**ARTICLE 16. QUALITY ASSURANCE/QUALITY ASSURANCE RECORD KEEPING**

The Contractor shall maintain, and shall require that its subcontractors and suppliers maintain, complete and accurate records to substantiate compliance with the requirements set forth in the Scope of Services. The Contractor and its subcontractors and suppliers, shall retain such records, and all other documents relevant to the Services furnished under this Agreement for a period of three (3) years from the expiration date of this Agreement and any extension thereof.

**ARTICLE 17. AUDITS**

The County, or its duly authorized representatives or governmental agencies, shall until the expiration of three (3) years after the expiration of this Agreement and any extension thereof, have annual access to and the right to examine and reproduce any of the Contractor's books, documents, papers and records and of its subcontractors and suppliers which apply to all matters of the County. Such records shall subsequently conform to Generally Accepted Accounting Principles requirements, as applicable, and shall only address those transactions related to this Agreement.

Pursuant to Section 2-481 of the Miami-Dade County Code, the Contractor will grant access to the Commission Auditor to all financial and performance related records, property, and equipment purchased in whole or in part with government funds. The Contractor agrees to maintain an accounting system that provides accounting records that are supported with adequate documentation, and adequate procedures for determining the allowability and allocability of costs.

**ARTICLE 18. SUBSTITUTION OF PERSONNEL**

In the event the Contractor wishes to substitute personnel for the key personnel identified by the Contractor's Proposal, the Contractor must notify the County in writing and request written approval for the substitution at least ten (10) business days prior to effecting such substitution.

**ARTICLE 19. CONSENT OF THE COUNTY REQUIRED FOR ASSIGNMENT**

The Contractor shall not assign, transfer, convey or otherwise dispose of this Agreement, including its rights, title or interest in or to the same or any part thereof without the prior written consent of the County.

**ARTICLE 20. SUBCONTRACTUAL RELATIONS**

- a) If the Contractor will cause any part of this Agreement to be performed by a Subcontractor, the provisions of this Contract will apply to such Subcontractor and its officers, agents and employees in all respects as if it and they were employees of the Contractor; and the Contractor will not be in any manner thereby discharged from its obligations and liabilities hereunder, but will be liable hereunder for all acts and negligence of the Subcontractor, its officers, agents, and employees, as if they were employees of the Contractor. The services performed by the Subcontractor will be subject to the provisions hereof as if performed directly by the Contractor.

- b) The Contractor, before making any subcontract for any portion of the services, will state in writing to the County the name of the proposed Subcontractor, the portion of the Services which the Subcontractor is to do, the place of business of such Subcontractor, and such other information as the County may require. The County will have the right to require the Contractor not to award any subcontract to a person, firm or corporation disapproved by the County.
- c) Before entering into any subcontract hereunder, the Contractor will inform the Subcontractor fully and completely of all provisions and requirements of this Agreement relating either directly or indirectly to the Services to be performed. Such Services performed by such Subcontractor will strictly comply with the requirements of this Contract.
- d) In order to qualify as a Subcontractor satisfactory to the County, in addition to the other requirements herein provided, the Subcontractor must be prepared to prove to the satisfaction of the County that it has the necessary facilities, skill and experience, and ample financial resources to perform the Services in a satisfactory manner. To be considered skilled and experienced, the Subcontractor must show to the satisfaction of the County that it has satisfactorily performed services of the same general type which is required to be performed under this Agreement.
- e) The County shall have the right to withdraw its consent to a subcontract if it appears to the County that the subcontract will delay, prevent, or otherwise impair the performance of the Contractor's obligations under this Agreement. All Subcontractors are required to protect the confidentiality of the County's and County's proprietary and confidential information. Contractor shall furnish to the County copies of all subcontracts between Contractor and Subcontractors and suppliers hereunder. Within each such subcontract, there shall be a clause for the benefit of the County in the event the County finds the Contractor in breach of this Contract, permitting the County to request completion by the Subcontractor of its performance obligations under the subcontract. The clause shall include an option for the County to pay the Subcontractor directly for the performance by such Subcontractor. Notwithstanding, the foregoing shall neither convey nor imply any obligation or liability on the part of the County to any subcontractor hereunder as more fully described herein.

**ARTICLE 21. ASSUMPTION, PARAMETERS, PROJECTIONS, ESTIMATES AND EXPLANATIONS**

The Contractor understands and agrees that any assumptions, parameters, projections, estimates and explanations presented by the County were provided to the Contractor for evaluation purposes only. However, since these assumptions, parameters, projections, estimates and explanations represent predictions of future events the County makes no representations or guarantees; and the County shall not be responsible for the accuracy of the assumptions presented; and the County shall not be responsible for conclusions to be drawn therefrom; and any assumptions, parameters, projections, estimates and explanations shall not form the basis of any claim by the Contractor. The Contractor accepts all risk associated with using this information.

**ARTICLE 22. SEVERABILITY**

If this Agreement contains any provision found to be unlawful, the same shall be deemed to be

of no effect and shall be deemed stricken from this Agreement without affecting the binding force of this Agreement as it shall remain after omitting such provision.

**ARTICLE 23. TERMINATION AND SUSPENSION OF WORK**

- a) The County may terminate this Agreement if an individual or corporation or other entity attempts to meet its contractual obligation with the County through fraud, misrepresentation or material misstatement.
- b) The County may, as a further sanction, terminate or cancel any other contract(s) that such individual or corporation or other entity has with the County and that such individual, corporation or other entity shall be responsible for all direct and indirect costs associated with such termination or cancellation, including attorney's fees.
- c) The foregoing notwithstanding, any individual, corporation or other entity which attempts to meet its contractual obligations with the County through fraud, misrepresentation or material misstatement may be debarred from County contracting for up to five (5) years in accordance with the County debarment procedures. The Contractor may be subject to debarment for failure to perform and all other reasons set forth in Section 10-38 of the County Code.
- d) In addition to cancellation or termination as otherwise provided in this Agreement, the County may at any time, in its sole discretion, with or without cause, terminate this Agreement by written notice to the Contractor.
- e) In the event that the County exercises its right to terminate this Agreement, the Contractor shall, upon receipt of such notice, unless otherwise directed by the County:
  - i. stop work on the date specified in the notice ("the Effective Termination Date");
  - ii. take such action as may be necessary for the protection and preservation of the County's materials and property;
  - iii. cancel orders;
  - iv. assign to the County and deliver to any location designated by the County any non-cancelable orders for Deliverables that are not capable of use except in the performance of this Agreement and has been specifically developed for the sole purpose of this Agreement and not incorporated in the Services;
  - v. take no action which will increase the amounts payable by the County under this Agreement; and
- f) In the event that the County exercises its right to terminate this Agreement, the Contractor will be compensated as stated in the payment Articles herein for the:
  - i. portion of the Services completed in accordance with the Agreement up to the Effective Termination Date; and
  - ii. non-cancelable Deliverables that are not capable of use except in the performance of this Agreement and has been specifically developed for the sole purpose of this Agreement, but not incorporated in the Services.

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- g) All compensation pursuant to this Article are subject to audit.

**ARTICLE 24. EVENT OF DEFAULT**

- a) An Event of Default shall mean a breach of this Agreement by the Contractor. Without limiting the generality of the foregoing, and in addition to those instances referred to herein as a breach, an Event of Default shall include the following:
- i. the Contractor has not delivered Deliverables on a timely basis;
  - ii. the Contractor has refused or failed to supply enough properly skilled staff personnel;
  - iii. the Contractor has failed to make prompt payment to network providers, subcontractors or suppliers for any Services;
  - iv. the Contractor has become insolvent (other than as interdicted by the bankruptcy laws), or has assigned the proceeds received for the benefit of the Contractor's creditors, or the Contractor has taken advantage of any insolvency statute or debtor/creditor law or if the Contractor's affairs have been put in the hands of a receiver;
  - v. the Contractor has failed to obtain the approval of the County where required by this Agreement;
  - vi. the Contractor has failed to provide "adequate assurances" as required under subsection b below;
  - vii. the Contractor has failed in the representation of any warranties stated herein;
  - viii. the Contractor has breached a provision of the Miami-Dade County HIPAA Business Associate Addendum as stated in Appendix C, attached to this Agreement.
- b) When, in the opinion of the County, reasonable grounds for uncertainty exist with respect to the Contractor's ability to perform the Services or any portion thereof, the County may request that the Contractor, within the timeframe set forth in the County's request, provide adequate assurances to the County, in writing, of the Contractor's ability to perform in accordance with the terms of this Agreement. Until the County receives such assurances, the County may request an adjustment to the compensation received by the Contractor for portions of the Services which the Contractor has not performed. In the event that the Contractor fails to provide to the County the requested assurances within the prescribed timeframe, the County may:
- i. treat such failure as a repudiation of this Agreement; and
  - ii. resort to any remedy for breach provided herein or at law, including but not limited to, taking over the performance of the Services or any part thereof either by itself or through others.
- c) In the event the County shall terminate this Agreement for default, the County or its designated representatives may immediately take possession of all applicable equipment, materials, products, documentation, reports and data.

**ARTICLE 25. NOTICE OF DEFAULT - OPPORTUNITY TO CURE**

If an Event of Default occurs in the determination of the County, the County may so notify the Contractor ("Default Notice"), specifying the basis for such default, and advising the Contractor that such default must be cured immediately or this Agreement with the County may be terminated. Notwithstanding, the County may, in its sole discretion, allow the Contractor to rectify the default to the County's reasonable satisfaction within a thirty (30) day period. The County may grant an additional period of such duration as the County shall deem appropriate without waiver of any of the County's rights hereunder, so long as the Contractor has commenced curing such default and is effectuating a cure with diligence and continuity during such thirty (30) day period or any other period which the County prescribes. The default notice shall specify the date the Contractor shall discontinue the Services upon the Termination Date.

**ARTICLE 26. REMEDIES IN THE EVENT OF DEFAULT**

If an Event of Default occurs, the Contractor shall be liable for all damages resulting from the default, including but not limited to:

- a) lost revenues;
- b) the difference between the cost associated with procuring Services hereunder and the amount actually expended by the County for re-procurement of Services, including procurement and administrative costs; and
- c) such other direct damages.

The Contractor shall also remain liable for any liabilities and claims related to the Contractor's default. The County may also bring any suit or proceeding for specific performance or for an injunction.

**ARTICLE 27. PATENT AND COPYRIGHT INDEMNIFICATION**

- a) The Contractor shall not infringe on any copyrights, trademarks, service marks, trade secrets, patent rights, other intellectual property rights or any other third party proprietary rights in the performance of the Work.
- b) The Contractor warrants that all Deliverables furnished hereunder, including but not limited to: equipment, programs, documentation, software, analyses, applications, methods, ways, processes, and the like, do not infringe upon or violate any copyrights, trademarks, service marks, trade secrets, patent rights, other intellectual property rights or any other third party proprietary rights.
- c) The Contractor shall be liable and responsible for any and all claims made against the County for infringement of patents, copyrights, service marks, trade secrets or any other third party proprietary rights, by the use or supplying of any programs, documentation, software, analyses, applications, methods, ways, processes, and the like, in the course of performance or completion of, or in any way connected with, the Work, or the County's continued use of the Deliverables furnished hereunder. Accordingly, the Contractor at its own expense, including the payment of attorney's fees, shall indemnify, and hold harmless the County and defend any action brought against the County with

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respect to any claim, demand, cause of action, debt, or liability.

- d) In the event any Deliverable or anything provided to the County hereunder, or portion thereof is held to constitute an infringement and its use is or may be enjoined, the Contractor shall have the obligation to, at the County's option to (i) modify, or require that the applicable subcontractor or supplier modify, the alleged infringing item(s) at its own expense, without impairing in any respect the functionality or performance of the item(s), or (ii) procure for the County, at the Contractor's expense, the rights provided under this Agreement to use the item(s).
- e) The Contractor shall be solely responsible for determining and informing the County whether a prospective supplier or subcontractor is a party to any litigation involving patent or copyright infringement, service mark, trademark, violation, or proprietary rights claims or is subject to any injunction which may prohibit it from providing any Deliverable hereunder. The Contractor shall enter into agreements with all suppliers and subcontractors at the Contractor's own risk. The County may reject any Deliverable that it believes to be the subject of any such litigation or injunction, or if, in the County's judgment, use thereof would delay the Work or be unlawful.

#### **ARTICLE 28. CONFIDENTIALITY**

- a) All Developed Works and other materials, data, transactions of all forms, financial information, documentation, inventions, designs and methods obtained from the County in connection with the Services performed under this Agreement, made or developed by the Contractor or its subcontractors in the course of the performance of such Services, or the results of such Services, or which the County holds the proprietary rights, constitute Confidential Information and may not, without the prior written consent of the County, be used by the Contractor or its employees, agents, subcontractors or suppliers for any purpose other than for the benefit of the County, unless required by law. In addition to the foregoing, all County employee information and County financial information shall be considered Confidential Information and shall be subject to all the requirements stated herein. Neither the Contractor nor its employees, agents, subcontractors or suppliers may sell, transfer, publish, disclose, display, license or otherwise make available to others any part of such Confidential Information without the prior written consent of the County. Additionally, the Contractor expressly agrees to be bound by and to defend, indemnify and hold harmless the County, and their officers and employees from the breach of any federal, state or local law in regard to the privacy of individuals.
- b) The Contractor shall advise each of its employees, agents, subcontractors and suppliers who may be exposed to such Confidential Information of their obligation to keep such information confidential and shall promptly advise the County in writing if it learns of any unauthorized use or disclosure of the Confidential Information by any of its employees or agents, or subcontractor's or supplier's employees, present or former. In addition, the Contractor agrees to cooperate fully and provide any assistance necessary to ensure the confidentiality of the Confidential Information.
- c) It is understood and agreed that in the event of a breach of this Article damages may not be an adequate remedy and the County shall be entitled to injunctive relief to restrain any such breach or threatened breach. Unless otherwise requested by the County, upon the completion of the Services performed hereunder, the Contractor shall

immediately turn over to the County all such Confidential Information existing in tangible form, and no copies thereof shall be retained by the Contractor or its employees, agents, subcontractors or suppliers without the prior written consent of the County. A certificate evidencing compliance with this provision and signed by an officer of the Contractor shall accompany such materials.

**ARTICLE 29. PROPRIETARY INFORMATION**

As a political subdivision of the State of Florida, Miami-Dade County is subject to the stipulations of Florida's Public Records Law.

The Contractor acknowledges that all computer software in the County's possession may constitute or contain information or materials which the County has agreed to protect as proprietary information from disclosure or unauthorized use and may also constitute or contain information or materials which the County has developed at its own expense, the disclosure of which could harm the County's proprietary interest therein.

During the term of the contract, the Contractor will not use directly or indirectly for itself or for others, or publish or disclose to any third party, or remove from the County's property, any computer programs, data compilations, or other software which the County has developed, has used or is using, is holding for use, or which are otherwise in the possession of the County (hereinafter "Computer Software"). All third-party license agreements must also be honored by the contractors and their employees, except as authorized by the County and, if the Computer Software has been leased or purchased by the County, all hired party license agreements must also be honored by the contractors' employees with the approval of the lessor or Contractors thereof. This includes mainframe, minis, telecommunications, personal computers and any and all information technology software.

The Contractor will report to the County any information discovered or which is disclosed to the Contractor which may relate to the improper use, publication, disclosure or removal from the County's property of any information technology software and hardware and will take such steps as are within the Contractor's authority to prevent improper use, disclosure or removal.

**ARTICLE 30. PROPRIETARY RIGHTS**

- a) The Contractor hereby acknowledges and agrees that the County retains all rights, title and interests in and to all materials, data, documentation and copies thereof furnished by the County to the Contractor hereunder or furnished by the Contractor to the County and/or created by the Contractor for delivery to the County, even if unfinished or in process, as a result of the Services the Contractor performs in connection with this Agreement, including all copyright and other proprietary rights therein, which the Contractor as well as its employees, agents, subcontractors and suppliers may use only in connection with the performance of Services under this Agreement. The Contractor shall not, without the prior written consent of the County, use such documentation on any other project in which the Contractor or its employees, agents, subcontractors or suppliers are or may become engaged. Submission or distribution by the Contractor to meet official regulatory requirements or for other purposes in connection with the performance of Services under this Agreement shall not be construed as publication in derogation of the County's copyrights or other proprietary rights.

- b) All rights, title and interest in and to certain inventions, ideas, designs and methods, specifications and other documentation related thereto developed by the Contractor and its subcontractors specifically for the County, hereinafter referred to as "Developed Works" shall become the property of the County.
- c) Accordingly, neither the Contractor nor its employees, agents, subcontractors or suppliers shall have any proprietary interest in such Developed Works. The Developed Works may not be utilized, reproduced or distributed by or on behalf of the Contractor, or any employee, agent, subcontractor or supplier thereof, without the prior written consent of the County, except as required for the Contractor's performance hereunder.
- d) Except as otherwise provided in subsections a, b, and c above, or elsewhere herein, the Contractor and its subcontractors and suppliers hereunder shall retain all proprietary rights in and to all Licensed Software provided hereunder, that have not been customized to satisfy the performance criteria set forth in the Scope of Services. Notwithstanding the foregoing, the Contractor hereby grants, and shall require that its subcontractors and suppliers grant, if the County so desires, a perpetual, irrevocable and unrestricted right and license to use, duplicate, disclose and/or permit any other person(s) or entity(ies) to use all such Licensed Software and the associated specifications, technical data and other Documentation for the operations of the County or entities controlling, controlled by, under common control with, or affiliated with the County, or organizations which may hereafter be formed by or become affiliated with the County. Such license specifically includes, but is not limited to, the right of the County to use and/or disclose, in whole or in part, the technical documentation and Licensed Software, including source code provided hereunder, to any person or entity outside the County for such person's or entity's use in furnishing any and/or all of the Deliverables provided hereunder exclusively for the County or entities controlling, controlled by, under common control with, or affiliated with the County, or organizations which may hereafter be formed by or become affiliated with the County. No such License Software, specifications, data, documentation or related information shall be deemed to have been given in confidence and any statement or legend to the contrary shall be void and of no effect.

### **ARTICLE 31. VENDOR REGISTRATION/CONFLICT OF INTEREST**

#### **a) Vendor Registration**

The Contractor shall be a registered vendor with the County – Internal Services Department, Procurement Management Division, for the duration of this Agreement. In becoming a Registered Vendor with Miami-Dade County, the Contractor confirms its knowledge of and commitment to comply with the following:

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|--|---|
| 1. <b>Miami-Dade County Ownership Disclosure Affidavit</b><br>(Section 2-8.1 of the County Code)             | (Section 10.38 of the County Code)  |
| 2. <b>Miami-Dade County Employment Disclosure Affidavit</b><br>(Section 2-8-1(d)(2) of the County Code)      | 6. <b>Miami-Dade County Vendor Obligation to County Affidavit</b><br>(Section 2-8.1 of the County Code)   |
| 3. <b>Miami-Dade Employment Drug-free Workplace Certification</b><br>(Section 2-8.1.2(b) of the County Code) | 7. <b>Miami-Dade County Code of Business Ethics Affidavit</b><br>(Section 2-8.1(f) and 2-11(b)(1) of the County Code through (6) and (9) of the County Code and Section 2-11.1(c) of the County Code) |
| 4. <b>Miami-Dade Disability and Nondiscrimination Affidavit</b><br>(Section 2-8.1.5 of the County Code)      | 8. <b>Miami-Dade County Family Leave Affidavit</b><br>(Article V of Chapter 11 of the County Code)  |
| 5. <b>Miami-Dade County Debarment Disclosure Affidavit</b>   |   |

- 9. **Miami-Dade County Living Wage Affidavit**  
(Section 2-8.9 of the County Code)
- 10. **Miami-Dade County Domestic Leave and Reporting Affidavit**  
(Article 8, Section 11A-60 11A-67 of the County Code)
- 11. **Subcontracting Practices**  
(Ordinance 97-35)
- 12. **Subcontractor /Supplier Listing**  
(Section 2-8.8 of the County Code)
- 13. **Environmentally Acceptable Packaging**  
(Resolution R-738-92)
- 14. **W-9 and 8109 Forms**  
(as required by the Internal Revenue Service)
- 15. **FEIN Number or Social Security Number**  
In order to establish a file, the Contractor's Federal Employer Identification Number (FEIN) must be provided. If no FEIN exists, the Social Security Number of the owner or individual must be provided. This number becomes Contractor's "County Vendor Number". To comply with Section 119.071(5) of the Florida Statutes relating to the collection of an

individual's Social Security Number, be aware that the County requests the Social Security Number for the following purposes:

- Identification of Individual account records
- To make payments to individual/Contractor for goods and services provided to Miami-Dade County
- Tax reporting purposes
- To provide a unique identifier in the vendor database that may be used for searching and sorting departmental records

- 16. **Office of the Inspector General**  
(Section 2-1076 of the County Code)
- 17. **Small Business Enterprises**  
The County endeavors to obtain the participation of all small business enterprises pursuant to Sections 2-8.2, 2-8.2.3 and 2-8.2.4 of the County Code and Title 49 of the Code of Federal Regulations.
- 18. **Antitrust Laws**  
By acceptance of any contract, the Contractor agrees to comply with all antitrust laws of the United States and the State of Florida.

**b) Conflict of Interest**

Section 2-11.1(d) of Miami-Dade County Code requires that any County employee or any member of the employee's immediate family who has a controlling financial interest, direct or indirect, with Miami-Dade County or any person or agency acting for Miami-Dade County, competing or applying for a contract, must first request a conflict of interest opinion from the County's Ethics Commission prior to their or their immediate family member's entering into any contract or transacting any business through a firm, corporation, partnership or business entity in which the employee or any member of the employee's immediate family has a controlling financial interest, direct or indirect, with Miami-Dade County or any person or agency acting for Miami-Dade County. Any such contract or business engagement entered in violation of this subsection, as amended, shall be rendered voidable. For additional information, please contact the Ethics Commission hotline at (305) 579-2593.

**ARTICLE 32. INSPECTOR GENERAL REVIEWS**

**Independent Private Sector Inspector General Reviews**

Pursuant to Miami-Dade County Administrative Order 3-20, the County has the right to retain the services of an Independent Private Sector Inspector General (hereinafter "IPSIG"), whenever the County deems it appropriate to do so. Upon written notice from the County, the Contractor shall make available to the IPSIG retained by the County, all requested records and documentation pertaining to this Agreement for inspection and reproduction. The County shall be responsible for the payment of these IPSIG services, and under no circumstance shall the Contractor's prices and any changes thereto approved by the County, be inclusive of any charges relating to these IPSIG services. The terms of this provision apply to the Contractor, its officers, agents, employees, subcontractors and assignees. Nothing contained in this provision shall impair any independent right of the County to conduct an audit or investigate the operations, activities and performance of the Contractor in connection with this Agreement. The terms of this Article shall not impose any liability on the County by the Contractor or any third party.

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**Miami-Dade County Inspector General Review**

According to Section 2-1076 of the Code of Miami-Dade County, Miami-Dade County has established the Office of the Inspector General which may, on a random basis, perform audits on all County contracts, throughout the duration of said contracts, except as otherwise provided below. The cost of the audit for this Contract shall be one quarter (1/4) of one (1) percent of the total contract amount which cost shall be included in the total contract amount. The audit cost will be deducted by the County from progress payments to the Contractor. The audit cost shall also be included in all change orders and all contract renewals and extensions.

**Exception:** The above application of one quarter (1/4) of one percent fee assessment shall not apply to the following contracts: (a) IPSIG contracts; (b) contracts for legal services; (c) contracts for financial advisory services; (d) auditing contracts; (e) facility rentals and lease agreements; (f) concessions and other rental agreements; (g) insurance contracts; (h) revenue-generating contracts; (i) contracts where an IPSIG is assigned at the time the contract is approved by the Commission; (j) professional service agreements under \$1,000; (k) management agreements; (l) small purchase orders as defined in Miami-Dade County Administrative Order 3-38; (m) federal, state and local government-funded grants; and (n) interlocal agreements. ***Notwithstanding the foregoing, the Miami-Dade County Board of County Commissioners may authorize the inclusion of the fee assessment of one quarter (1/4) of one percent in any exempted contract at the time of award.***

Nothing contained above shall in any way limit the powers of the Inspector General to perform audits on all County contracts including, but not limited to, those contracts specifically exempted above. The Miami-Dade County Inspector General is authorized and empowered to review past, present and proposed County and Public Health Trust contracts, transactions, accounts, records and programs. In addition, the Inspector General has the power to subpoena witnesses, administer oaths, require the production of records and monitor existing projects and programs. Monitoring of an existing project or program may include a report concerning whether the project is on time, within budget and in conformance with plans, specifications and applicable law. The Inspector General is empowered to analyze the necessity of and reasonableness of proposed change orders to the Contract. The Inspector General is empowered to retain the services of independent private sector inspectors general (IPSIG) to audit, investigate, monitor, oversee, inspect and review operations, activities, performance and procurement process, including but not limited to project design, specifications, proposal submittals, activities of the Contractor, its officers, agents and employees, lobbyists, County staff and elected officials to ensure compliance with contract specifications and to detect fraud and corruption.

Upon written notice to the Contractor from the Inspector General or IPSIG retained by the Inspector General, the Contractor shall make all requested records and documents available to the Inspector General or IPSIG for inspection and copying. The Inspector General and IPSIG shall have the right to inspect and copy all documents and records in the Contractor's possession, custody or control which, in the Inspector General's or IPSIG's sole judgment, pertain to performance of the contract, including, but not limited to original estimate files, change order estimate files, worksheets, proposals and agreements form and which successful and unsuccessful subcontractors and suppliers, all project-related correspondence, memoranda, instructions, financial documents, construction documents, proposal and contract documents, back-charge documents, all documents and records which involve cash, trade or volume discounts, insurance proceeds, rebates, or dividends received, payroll and personnel records, and supporting documentation for the aforesaid documents and records.

This Agreement is recognized as an insurance contract and is therefore not subject to the one quarter (1/4) of one percent fee assessment, subject to the "Notwithstanding Clause" stated above.

**ARTICLE 33. LOCAL, STATE, AND FEDERAL COMPLIANCE REQUIREMENTS**

Contractor agrees to comply, subject to applicable professional standards, with the provisions of any and all applicable Federal, State and the County orders, statutes, ordinances, rules and regulations which may pertain to the Services required under this Agreement, including, but not limited to:

- a) Equal Employment Opportunity (EEO), in compliance with Executive Order 11246 as amended and applicable to this Contract.
- b) Miami-Dade County Florida, Department of Small Business Development Participation Provisions, as applicable to this Contract.
- c) Environmental Protection Agency (EPA), as applicable to this Contract.
- d) Miami-Dade County Code, Chapter 11A, Article 3. All contractors and subcontractors performing work in connection with this Contract shall provide equal opportunity for employment without regard to race, color, religion, ancestry, national origin, sex, pregnancy, age, disability, marital status, familial status, sexual orientation, or veteran status. The aforesaid provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer, recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor agrees to post in a conspicuous place available for employees and applicants for employment, such notices as may be required by the Dade County Fair Housing and Employment Commission, or other authority having jurisdiction over the work setting forth the provisions of the nondiscrimination law.
- e) "Conflicts of Interest" Section 2-11 of the County Code, and Ordinance 01-199.
- f) Miami-Dade County Code Section 10-38 "Debarment".
- g) Miami-Dade County Ordinance 99-5, codified at 11A-60 et. seq. of Miami-Dade Code pertaining to complying with the County's Domestic Leave Ordinance.
- h) Miami-Dade County Ordinance 99-152, prohibiting the presentation, maintenance, or prosecution of false or fraudulent claims against Miami-Dade County.

In the performance of the administrative services with respect to the County Plans (POS and HMO), Contractor shall comply with the regulations set forth in Title 45 CFR Part 149.35 regarding the maintenance, including retention periods, and disclosure of information, data, documents, and records to the Secretary of the Health and Human Services (HHS) as necessary for the County to comply with the Early Retiree Reinsurance Program. The information provided may be utilized by the County for purposes of obtaining Federal funds.

The Contractor shall hold all licenses and/or certifications, obtain and pay for all permits and/or inspections, and comply with all laws, ordinances, regulations and building code requirements applicable to the work required herein. Damages, penalties, and/or fines imposed on the County or Contractor for failure to obtain and maintain required licenses, certifications, permits

and/or inspections shall be borne by the Contractor. The Project Manager shall verify the certification(s), license(s), permit(s), etc. for the Contractor prior to authorizing work and as needed.

Notwithstanding any other provision of this Agreement, Contractor shall not be required pursuant to this Agreement to take any action or abstain from taking any action if such action or abstention would, in the good faith determination of the Contractor, constitute a violation of any law or regulation to which Contractor is subject, including but not limited to laws and regulations requiring that Contractor conduct its operations in a safe and sound manner.

**ARTICLE 34. NONDISCRIMINATION**

During the performance of this Contract, Contractor agrees to not discriminate against any employee or applicant for employment because of race, color, religion, ancestry, national origin, sex, pregnancy, age, disability, marital status, familial status, sexual orientation, gender identity or gender expression, status as victim of domestic violence, dating violence or stalking, or veteran status, and will take affirmative action to ensure that employees and applicants are afforded equal employment opportunities without discrimination. Such action shall be taken with reference to, but not limited to: recruitment, employment, termination, rates of pay or other forms of compensation, and selection for training or retraining, including apprenticeship and on the job training.

By entering into this Contract, the Contractor attests that it is not in violation of the Americans with Disabilities Act of 1990 (and related Acts) or Miami-Dade County Resolution No. R-385-95. If the Contractor or any owner, subsidiary or other firm affiliated with or related to the Contractor is found by the responsible enforcement agency or the County to be in violation of the Act or the Resolution, such violation shall render this Contract void. This Contract shall be void if the Contractor submits a false affidavit pursuant to this Resolution or the Contractor violates the Act or the Resolution during the term of this Contract, even if the Contractor was not in violation at the time it submitted its affidavit.

**ARTICLE 35. CONFLICT OF INTEREST**

The Contractor represents that:

- a) No officer, director, employee, agent, or other consultant of the County or a member of the immediate family or household of the aforesaid has directly or indirectly received or been promised any form of benefit, payment or compensation, whether tangible or intangible, in connection with the award of this Agreement.
- b) There are no undisclosed persons or entities interested with the Contractor in this Agreement. This Agreement is entered into by the Contractor without any connection with any other entity or person making a proposal for the same purpose, and without collusion, fraud or conflict of interest. No elected or appointed officer or official, director, employee, agent or other consultant of the County, or of the State of Florida (including elected and appointed members of the legislative and executive branches of government), or a member of the immediate family or household of any of the aforesaid:
  - i) is interested on behalf of or through the Contractor directly or indirectly in any manner whatsoever in the execution or the performance of this Agreement, or in the services, supplies or work, to which this Agreement relates or in any portion of the revenues; or

- ii) is an employee, agent, advisor, or consultant to the Contractor or to the best of the Contractor's knowledge any subcontractor or supplier to the Contractor.
- c) Neither the Contractor nor any officer, director, employee, agency, parent, subsidiary, or affiliate of the Contractor shall have an interest which is in conflict with the Contractor's faithful performance of its obligation under this Agreement; provided that the County, in its sole discretion, may consent in writing to such a relationship, provided the Contractor provides the County with a written notice, in advance, which identifies all the individuals and entities involved and sets forth in detail the nature of the relationship and why it is in the County's best interest to consent to such relationship.
- d) The provisions of this Article are supplemental to, not in lieu of, all applicable laws with respect to conflict of interest. In the event there is a difference between the standards applicable under this Agreement and those provided by statute, the stricter standard shall apply.
- e) In the event Contractor has no prior knowledge of a conflict of interest as set forth above and acquires information which may indicate that there may be an actual or apparent violation of any of the above, Contractor shall promptly bring such information to the attention of the County's Project Manager. Contractor shall thereafter cooperate with the County's review and investigation of such information, and comply with the instructions Contractor receives from the Project Manager in regard to remedying the situation.

**ARTICLE 36. PRESS RELEASE OR OTHER PUBLIC COMMUNICATION**

Under no circumstances shall the Contractor without the express written consent of the County:

- a) Issue or permit to be issued any press release, advertisement or literature of any kind which refers to the County, or the Work being performed hereunder, unless the Contractor first obtains the written approval of the County. Such approval may be withheld if for any reason the County believes that the publication of such information would be harmful to the public interest or is in any way undesirable; and
- b) Communicate in any way with any contractor, department, board, agency, commission or other organization or any person whether governmental or private in connection with the Services to be performed hereunder except upon prior written approval and instruction of the County; and
- c) Except as may be required by law, the Contractor and its employees, agents, subcontractors and suppliers will not represent, directly or indirectly, that any product or service provided by the Contractor or such parties has been approved or endorsed by the County.

**ARTICLE 37. BANKRUPTCY**

The County reserves the right to terminate this contract, if, during the term of any contract the Contractor has with the County, the Contractor becomes involved as a debtor in a bankruptcy proceeding, or becomes involved in a reorganization, dissolution, or liquidation proceeding, or if a trustee or receiver is appointed over all or a substantial portion of the property of the Contractor under federal bankruptcy law or any state insolvency law.

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**ARTICLE 38. GOVERNING LAW**

This Contract, including appendices, and all matters relating to this Contract (whether in contract, statute, tort (such as negligence), or otherwise) shall be governed by, and construed in accordance with, the laws of the State of Florida. Venue shall be Miami-Dade County.

**ARTICLE 39. FIRST SOURCE HIRING REFERRAL PROGRAM**

Pursuant to Section 2-2113 of the Code of Miami-Dade County, for all contracts for goods and services, the Contractor, prior to hiring to fill each vacancy arising under a County contract shall (1) first notify the South Florida Workforce Investment Board ("SFWIB"), the designated Referral Agency, of the vacancy and list the vacancy with SFWIB according to the Code, and (2) make good faith efforts as determined by the County to fill a minimum of fifty percent (50%) of its employment needs under the County contract through the SFWIB. If no suitable candidates can be employed after a Referral Period of three to five days, the Contractor is free to fill its vacancies from other sources. Contractor will be required to provide quarterly reports to the SFWIB indicating the name and number of employees hired in the previous quarter, or why referred candidates were rejected. Sanctions for non-compliance shall include, but not be limited to: (i) suspension of contract until Contractor performs obligations, if appropriate; (ii) default and/or termination; and (iii) payment of \$1,500/employee, or the value of the wages that would have been earned given the noncompliance, whichever is less. Registration procedures and additional information regarding the FSHRP are available at <https://iapps.southfloridaworkforce.com/firstsource/>.

**ARTICLE 40. PUBLIC RECORDS AND CONTRACTS FOR SERVICES PERFORMED ON BEHALF OF A PUBLIC AGENCY**

The Contractor shall comply with the state of FL Public Records Law, s. 119.0701, F.S., specifically to: (1) keep and maintain public records that ordinarily and necessarily would be required by the public agency in order to perform the service; (2) provide the public with access to public records on the same terms and conditions that the public agency would provide the records and at a cost that does not exceed the cost provided in Chapter 119, F.S., or as otherwise provided by law; (3) ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law; and (4) meet all requirements for retaining public records and transfer, at no cost, to the public agency all public records in possession of the Contractor upon termination of the contract and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. All records stored electronically must be provided to the public agency in a format that is compatible with the information technology systems of the public agency. If the Contractor does not comply with a public records request, the public agency shall enforce contract provisions in accordance with the contract.

**ARTICLE 41. MODIFICATIONS OR AMENDMENTS**

The parties agree that the Self-funded Employee Group Healthcare Program, to include the Plan Design, may be modified or amended as follows:

- a. To realize cost savings for the County and its employees, while maintaining a

comprehensive level of healthcare for County employees, retirees and their eligible dependents;

b. To implement modifications to the Plan Design through the addition or alteration of benefit design options;

c. To carve out any component/service of the Program (i.e., pharmacy, wellness, etc.) that is determined by the County, at its sole discretion, to warrant a separate program, or in combination with another commodity program.

d. To achieve the County's, and its employee's best interest, at the County's sole discretion.

Modification or amendment of the Program shall be communicated in writing by the County to the Contractor. The Contractor may submit recommendations for modifications or amendments to the County for consideration. The County may consider the recommendation and further negotiate with the Contractor to incorporate or carve out any or all of the recommendations, at its sole discretion. Implementation of the modification or amendment shall be mutually agreed upon by the County and the Contractor subject to processing systems, effective dates, and procedure changes necessary by the modification or amendment.

Any such modification or amendment (and the revised charge (+/-), if any, applicable thereto) shall be evidenced by a supplemental agreement between the parties which, upon execution, shall become a part of this Agreement.

**ARTICLE 42. SURVIVAL**

The parties acknowledge that any of the obligations in this Agreement will survive the term, termination and cancellation hereof. Accordingly, the respective obligations of the Contractor and the County under this Agreement, which by nature would continue beyond the termination, cancellation or expiration thereof, shall survive termination, cancellation or expiration hereof.

**ARTICLE 43. INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION and/or PROTECTED HEALTH INFORMATION**

Any person or entity that performs or assists Miami-Dade County with a function or activity involving the use or disclosure of "Individually Identifiable Health Information (IIHI) and/or Protected Health Information (PHI) shall comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Miami-Dade County Privacy Standards Administrative Order. HIPAA mandates for privacy, security and electronic transfer standards, include but are not limited to:

1. Use of information only for performing services required by the contract or as required by law;
2. Use of appropriate safeguards to prevent non-permitted disclosures;
3. Reporting to Miami-Dade County of any non-permitted use or disclosure;
4. Assurances that any agents and subcontractors agree to the same restrictions and conditions that apply to the Contractor and reasonable assurances that IIHI/PHI will be held confidential;
5. Making Protected Health Information (PHI) available to the customer;

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- 6. Making PHI available to the customer for review and amendment; and incorporating any amendments requested by the customer;
- 7. Making PHI available to Miami-Dade County for an accounting of disclosures; and
- 8. Making internal practices, books and records related to PHI available to Miami-Dade County for compliance audits.

PHI shall maintain its protected status regardless of the form and method of transmission (paper records, and/or electronic transfer of data). The Contractor must give its customers written notice of its privacy information practices including specifically, a description of the types of uses and disclosures that would be made with protected health information.

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the contract date herein above set forth.

Contractor

Miami-Dade County

By: \_\_\_\_\_

By: \_\_\_\_\_

Name: \_\_\_\_\_

Name: Carlos A. Gimenez

Title: \_\_\_\_\_

Title: Mayor

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Attest: \_\_\_\_\_  
Corporate Secretary/Notary Public

Attest: \_\_\_\_\_  
Clerk of the Board

Corporate Seal/Notary Seal

Approved as to form  
and legal sufficiency

\_\_\_\_\_  
Assistant County Attorney

SS

## Appendix C

## HIPAA BUSINESS ASSOCIATE ADDENDUM

This HIPAA Business Associate Addendum ("Addendum") supplements and is made a part of the Agreement by and between the Miami-Dade County, Florida ("County"), and \_\_\_\_\_, Business Associate ("Associate").

## RECITALS

A. As part of the Agreement, it is necessary for the County to disclose certain information ("Information") to Associate pursuant to the terms of the Agreement, some of which may constitute Protected Health Information ("PHI").

B. County and Associate intend to protect the privacy and provide for the security of PHI, including but not limited to, ePHI, disclosed to Associate pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws.

C. The purpose of this Addendum is to satisfy certain standards and requirements of HIPAA and the HIPAA Regulations, including, but not limited to, Title 45, Sections 164.308(b), 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("CFR"), as the same may be amended from time to time.

In consideration of the mutual promises below and the exchange of information pursuant to the Agreement, the parties agree as follows:

1. **Definitions.** Terms used, but not otherwise defined, shall have the same meaning as those terms in 45 CFR Sections 160.103, 164.304 and 164.501.
  - a. "Business Associate" shall have the meaning given to such term under the HIPAA Regulations, including, but not limited to, 45 CFR Section 160.103.
  - b. "Covered Entity" shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR Section 160.103.
  - c. "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to 45 CFR Section 160.103. [45 CFR Parts 160, 162 and 164]
  - d. "Electronic Protected Health Information" or "ePHI" means any information that is transmitted or maintained in electronic media: (i) that relates to the past, present or future physical or mental condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual, and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to 45 CFR Section 160.103. [45 CFR Parts 160, 162 and 164]
  - e. "Electronic Media" shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including but not limited to, 45 CFR Section 160.103.
  - f. "Security incident" shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including but not limited to, 45 CFR Section 164.304.

## Appendix C

**2. Obligations of Associate.**

a. Permitted Uses and Disclosures. Associate may use and/or disclose PHI received by Associate pursuant to the Agreement ("County's PHI") solely in accordance with the specifications set forth in the Scope of Services, Appendix A. In the event of any conflict between this Addendum and Appendix A, this Addendum shall control. [45 CFR § 164.504(e)(2)(i)]

b. Nondisclosure. Associate shall not use or further disclose County's PHI other than as permitted or required by law. [45 CFR § 164.504(e)(2)(ii)(A)]

c. Safeguards. Associate shall use appropriate safeguards to prevent use or disclosure of County's PHI in a manner other than as provided in this Addendum. [45 CFR § 164.504(e)(2)(ii)(B)] Associate shall maintain a comprehensive written information security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Associate's operations and the nature and scope of its activities. Appropriate safeguards used by Associate shall protect the confidentiality, integrity, and availability of the PHI and ePHI that is created, received, maintained, or transmitted on behalf of the County. [45 CFR § 164.314(a)(2)(i)(A)] County has at its sole discretion, the option to audit and inspect, the Associate's safeguards at any time during the life of the Agreement, upon reasonable notice being given to Associate for production of documents and coordination of inspection(s).

d. Reporting of Disclosures. Associate shall report to the County's Project Manager, any use or disclosure of the County's PHI in a manner other than as provided in this Addendum. [45 CFR § 164.504(e)(2)(ii)(c)] Associate shall report to the County through the County's Project Manager, any security incident of which it becomes aware within forty-eight (48) hours of discovery of the incident. [45 CFR § 164.314(a)(2)(i)(C)]

e. Associate's Agents. Associate agrees and shall ensure that any agents, including subcontractors, to whom it provides PHI received from (or created or received by Associate on behalf of) the County, agrees in writing to the same restrictions and conditions that apply to Associate with respect to such PHI and that such agents conduct their operations within the United States. Associate agrees and shall ensure that any agents, including subcontractors, to whom it provides ePHI received, created, maintained, or transmitted on behalf of the County, agrees in writing to implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of that ePHI. [45 CFR § 164.314(a)(2)(i)(B)] In no case may Associate's Agents reside and operate outside of the United States.

f. Documentation of Disclosures. Associate agrees to document disclosures of the County's PHI and information related to such disclosures as would be required for the County to respond to a request by an individual for an accounting of disclosures of PHI. Associate agrees to provide the County or an individual, in a time and manner designated by the County, information collected in accordance with the Agreement, to permit the County to respond to such a request for an accounting. [45 CFR § 164.528]

g. Availability of Information to County. Associate shall make available to the County such information as the County may require to fulfill the County's obligations to provide access to, provide a copy of, and account for, disclosures of PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR Sections 164.524 and 164.528. [45 CFR § 164.504(e)(2)(ii)(E) and (G)]

h. Amendment of PHI. Associate shall make the County's PHI available to the County as may be required to fulfill the County's obligations to amend PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR Section 164.526 and Associate shall, as directed by the County, incorporate any amendments to the County's PHI into copies of such PHI maintained by Associate, and in the time and manner designated by the County. [45 CFR § 164.504(e)(2)(ii)(F)]

i. Internal Practices. Associate shall make its internal practices, books and records relating to the use and disclosure of the County's PHI (or PHI created or received by Associate on behalf of the County) available to the County and to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by the

## Appendix C

County or the Secretary for purposes of determining Associate's compliance with HIPAA and the HIPAA Regulations. [45 CFR § 164.504(e)(2)(ii)(H) and 45 CFR Part 64, Subpart C.]

j. Mitigation. Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the County's PHI by Associate in violation of the requirements of this Addendum.

k. Associate's Insurance. Associate agrees to maintain the insurance coverage provided in the Agreement.

l. Notification of Breach. Associate shall notify the County within twenty-four (24) hours, and shall provide written notice no later than forty-eight (48) hours of any suspected or actual breach of security, intrusion or unauthorized disclosure of PHI and/or any actual or suspected disclosure of data in violation of any applicable federal or state laws or regulations. Associate shall take (i) prompt corrective action to cure any such deficiencies, and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

m. Expenses. Any and all expenses incurred by Associate in compliance with the terms of this Addendum or in compliance with the HIPAA Regulations shall be borne by Associate.

n. No Third Party Beneficiary. The provisions and covenants set forth in this Agreement are expressly entered into only by and between Associate and the County and are intended only for their benefit. Neither Associate nor the County intends to create or establish any third party beneficiary status or right (or the equivalent thereof) in any other third party nor shall any other third party have any right to enforce or enjoy any benefit created or established by the provisions and covenants in this Agreement.

3. Audits, Inspection and Enforcement. From time to time, after reasonable notice, upon any breach of this Addendum by Associate, the County may inspect the facilities, systems, books and records of Associate to monitor compliance with this Addendum. Associate shall promptly remedy any violation of this Addendum and shall certify the same to the County in writing. The fact that the County inspects, or fails to utilize its right to inspect, Associate's facilities, systems, books, records, and procedures does not relieve Associate of its responsibility to comply with this Addendum, nor does the County's (i) failure to detect or (ii) detection, but failure to notify Associate or require Associate to remedy such breach, constitute acceptance of such practice or a waiver of the County's enforcement rights under this Addendum.

#### 4. Termination.

a. Material Breach. A breach by Associate of any provision of this Addendum, shall constitute a material breach of the Agreement and shall provide grounds for immediate termination of the Agreement by the County. [45 CFR § 164.504(e)(3) and 45 CFR § 164.314(a)(2)(i)(D)]

b. Termination for Cause - Reasonable Steps to Cure Breach. If the County recognizes a pattern of activity or practice of Associate that constitutes a material breach or violation of the Associate's obligations under the provisions of this Addendum and does not terminate the Agreement pursuant to Section 4a, above, the County may provide an opportunity for Associate to end the violation or cure the breach within five (5) days, or other cure period as may be specified in the Agreement. If Associate does not cure the breach or end the violation within the time period provided, the County may immediately terminate the Agreement.

c. Judicial or Administrative Proceedings. The County may terminate the Agreement, effective immediately, if (i) Associate is named as a defendant in a criminal or administrative proceeding for a violation of HIPAA, or (ii) a finding or stipulation that Associate has violated any standard or requirement of the HIPAA Regulations (or other security or privacy law) is made in any administrative or civil proceeding.

d. Effect of Termination. Upon termination of the Agreement for any reason, Associate shall return or destroy as directed by the County all PHI, including but not limited to ePHI, received from the County (or created or received by Associate on behalf of the County) that Associate still maintains in any form. This provision shall also apply to County PHI that is in the possession of subcontractors or agents of Associate. Associate shall retain no copies of such

## Appendix C

PHI or, if return or destruction is not feasible, Associate shall provide to the County notification of the conditions that make return or destruction infeasible, and shall continue to extend the protections of this Addendum to such information, and limit further use or disclosure of such PHI to those purposes that make the return or destruction of such PHI infeasible. [45 CFR § 164.504(e)(2)(i)(I)]

5. **Indemnification.** Associate shall indemnify and hold harmless the County and its officers, employees, trustees, agents, and instrumentalities (the indemnified parties) from any and all liability, losses or damages, including attorneys' fees and costs of defense, which the County or its officers, trustees, employees, agents or instrumentalities may incur as a result of claims, demands, suits, causes of actions or proceedings of any kind or nature arising out of, relating to, or resulting from the performance of this Addendum by Associate or its employees, agents, servants, partners, principals, or subcontractors. Associate shall pay all claims and losses in connection therewith and shall investigate and defend all claims, suits, or actions of any kind or nature in the name of any of the indemnified parties, where applicable, including appellate proceedings, and shall pay all costs, judgments, and attorney's fees which may issue thereon. Associate expressly understands and agrees that any insurance protection required by this Addendum, or otherwise provided by Associate, shall in no way limit the responsibility to indemnify, keep and save harmless and defend the indemnified parties as herein provided. This paragraph shall survive the termination of the Agreement.

6. **Limitation of Liability.** Nothing in this Addendum shall be construed to affect or limit the County's sovereign immunity as set forth in Florida Statutes, Section 768.28.

7. **Amendment.**

a. **Amendment to Comply with Law.** The parties acknowledge that state and federal laws relating to the security and privacy of PHI, including electronic data, are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that the County must receive satisfactory written assurance from Associate that Associate will adequately safeguard all PHI that it receives or creates pursuant to this Agreement. Upon the County's request, Associate agrees to promptly enter into an amendment to the Agreement embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA Regulations or other applicable laws. The County, in addition to any other remedies including specific performance, may terminate the Agreement upon five [5] days' written notice in the event Associate does not enter into said amendment to the Agreement providing assurances regarding the safeguarding of PHI that the County, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA Regulations. Notwithstanding Associate's failure to enter into an amendment, Associate shall comply with all provisions of the HIPAA laws.

b. **Amendment of Appendix C.** In addition to amendments described in 7a above, Appendix C may otherwise be modified or amended by written mutual agreement of the parties without amendment of the remainder of this Agreement."

8. **Assistance in Litigation or Administrative Proceedings.** Associate shall make itself, and any subcontractors, employees or agents assisting Associate in the performance of its obligations under this Agreement, available to the County at the County's convenience upon reasonable notice, at no cost to the County, to testify as witnesses, for document production, or otherwise, in the event of litigation or administrative proceedings being commenced against the County, its trustees, officers, agents or employees based upon claimed violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy, except where Associate or its subcontractor, employee or agent is a named adverse party.

9. **Effect on Agreement.** Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the Agreement shall remain in force and effect. In the event of any conflict between this Addendum and Agreement, this Addendum shall control.

Appendix C

10. **Interpretation.** This Addendum and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA Regulations and applicable Florida laws. The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA Regulations.

11. **Jurisdiction.** Any litigation between the parties regarding the terms of this Addendum shall take place in Miami-Dade County, Florida.

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**PROPOSAL SUBMISSION PACKAGE  
REQUEST FOR PROPOSALS (RFP) No. 00196  
SELF-FUNDED EMPLOYEE GROUP HEALTHCARE PROGRAM**

In response to the Solicitation, Proposer shall RETURN THIS ENTIRE PROPOSAL SUBMISSION PACKAGE as follows:

**1. Proposal Submittal Form, Cover Page of Proposal**

Complete and sign the Proposal Submittal Form (by Proposer or representative of the Proposer who is legally authorized to enter into a contractual relationship in the name of the Proposer) as required.

**2. Proposer Information**

Complete following the requirements therein.

*Note: The Proposer Information document is available in Word and is included in the Solicitation attachments.*

**3. Affidavits/Acknowledgements**

Complete and sign the following:

- Lobbyist Registration for Oral Presentation
- Fair Subcontracting Practices
- Subcontractor/Supplier Listing
- Contractor Due Diligence Affidavit

**4. Form B-1, Price/Financial Proposal Schedule**

Complete following the requirements therein.

Please refer to the front cover of this Solicitation for electronic submission instructions.



**Miami-Dade County  
Procurement Management Services  
Proposal Submittal Form**

111 NW 1<sup>st</sup> Street, Suite 1300, Miami, FL 33128

<b>Solicitation No.</b>		<b>Solicitation Title:</b>		
<b>Legal Company Name (include d/b/a if applicable):</b> <input style="width:100%;" type="text"/>		<b>Federal Tax Identification Number:</b> <input style="width:100%;" type="text"/>		
<b>If Corporation - Date Incorporated/Organized:</b> <input style="width:100%;" type="text"/>		<b>State Incorporated/Organized:</b> <input style="width:100%;" type="text"/>		
<b>Company Operating Address:</b> <input style="width:100%;" type="text"/>		<b>City</b> <input style="width:100%;" type="text"/>	<b>State</b> <input style="width:100%;" type="text"/>	<b>Zip Code</b> <input style="width:100%;" type="text"/>
<b>Company Contact Person:</b> <input style="width:100%;" type="text"/>		<b>Email Address:</b> <input style="width:100%;" type="text"/>		
<b>Phone Number (include area code):</b> <input style="width:100%;" type="text"/>	<b>Fax Number (include area code):</b> <input style="width:100%;" type="text"/>	<b>Company's Internet Web Address:</b> <input style="width:100%;" type="text"/>		
<p>Pursuant to Miami-Dade County Ordinance 94-34, any individual, corporation, partnership, joint venture or other legal entity having an officer, director, or executive who has been convicted of a felony during the past ten (10) years shall disclose this information prior to entering into a contract with or receiving funding from the County.</p> <p><input type="checkbox"/> Place a check mark here only if Proposer has such conviction to disclose to comply with this requirement.</p>				
<p><b>LOCAL PREFERENCE CERTIFICATION:</b> For the purpose of this certification, a "local business" is a business located within the limits of Miami-Dade County (or Broward County in accordance with the Interlocal Agreement between the two counties) that has a valid Local Business Tax Receipt, issued by Miami-Dade County; has a physical business address located within the limits of Miami-Dade County from which business is performed; and contributes to the economic development of the community in a verifiable and measurable way. This may include, but not be limited to, the retention and expansion of employment opportunities and the support and increase to the County's tax base.</p> <p><input type="checkbox"/> Place a check mark here only if affirming Proposer meets requirements for Local Preference. Failure to complete this certification at this time (by checking the box above) may render the vendor ineligible for Local Preference.</p>				
<p><b>LOCAL CERTIFIED SERVICE-DISABLED VETERAN BUSINESS ENTERPRISE CERTIFICATION:</b> A Local Certified Service-Disabled Veteran Business Enterprise is a firm that is (a) a local business pursuant to Section 2-8.5 of the Code of Miami-Dade County and (b) prior to proposal submission is certified by the State of Florida Department of Management Services as a service-disabled veteran business enterprise pursuant to Section 295.187 of the Florida Statutes.</p> <p><input type="checkbox"/> Place a check mark here only if affirming Proposer is a Local Certified Service-Disabled Veteran Business Enterprise. A copy of the certification must be submitted with this proposal.</p>				

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**SMALL BUSINESS ENTERPRISE CONTRACT MEASURES (If Applicable)**

An SBE/Micro Business Enterprise must be certified by Small Business Development for the type of goods and/or services the Proposer provides in accordance with the applicable Commodity Code(s) for this Solicitation. For certification information contact Small Business Development at (305) 375-2378 or access <http://www.miamidade.gov/business/business-certification-programs.asp>. The SBE/Micro Business Enterprise must be certified by proposal submission deadline, at contract award, and for the duration of the contract to remain eligible for the preference. Firms that graduate from the SBE program during the contract may remain on the contract.

Is your firm a Miami-Dade County Certified Small Business Enterprise?

Yes

No

If yes, please provide your Certification Number: \_\_\_\_\_

**SCRUTINIZED COMPANIES WITH ACTIVITIES IN SUDAN LIST OR THE SCRUTINIZED COMPANIES WITH ACTIVITIES IN THE IRAN PETROLEUM ENERGY SECTOR LIST:**

By executing this proposal through a duly authorized representative, the Proposer certifies that the Proposer is not on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, as those terms are used and defined in sections 287.135 and 215.473 of the Florida Statutes. In the event that the Proposer is unable to provide such certification but still seeks to be considered for award of this solicitation, the Proposer shall execute the proposal through a duly authorized representative and shall also initial this space: \_\_\_\_\_ In such event, the Proposer shall furnish together with its proposal response a duly executed written explanation of the facts supporting any exception to the requirement for certification that it claims under Section 287.135 of the Florida Statutes. The Proposer agrees to cooperate fully with the County in any investigation undertaken by the County to determine whether the claimed exception would be applicable. The County shall have the right to terminate any contract resulting from this solicitation for default if the Proposer is found to have submitted a false certification or to have been placed on the Scrutinized Companies for Activities In Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List.



Proposer's Authorized Representative's Signature:

Date

Type or Print Name

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# PROPOSER INFORMATION

RFP No. 00196

## Minimum Qualification Requirements

1. Provide documentation that demonstrates Proposer's ability to satisfy the minimum qualification requirements. Proposers who do not meet the minimum qualification requirements or who fail to provide supporting documentation may be deemed non-responsive. The minimum qualification requirements for this Solicitation are:
  - a. Proposer shall be licensed by the State of Florida to provide the plan services and/or administrative product for which the proposal is being submitted for, as of the proposal due date. Proposer shall provide proof of its Certificate of Authority, issued by the State of Florida, for the type of plan services or administrative product proposed.
  - b. Proposer shall be financially stable to render the services listed in the Scope of Services (Section 2), as of proposal due date. Proposer shall provide proof of its minimum A- financial rating from A. M. Best Company, and a "Classification of VII" or higher, as the Proposer's most recent rating. If such rating is not available or not applicable, the Proposer shall: 1) provide its most recent independently audited financial statements, to include auditor's notes, for each of its past two (2) fiscal years, or 2) the U.S. Securities and Exchange Commission's (SEC) Annual 10-K Report for its past two (2) fiscal years.

## Proposer's Experience, Past Performance and Qualification of its Key Personnel and its Subcontractors' Key Personnel Performing Services

2. Provide a brief (one page or less) history of the Proposer's organization including ownership structure and any other organization with which the Proposer is affiliated. Identify any subcontractors that the Proposer is proposing for this solicitation (be specific regarding Pharmacy Benefits Manager (PBM) and Wellness/Disease Management services). Is the Proposer or any affiliated subcontractors involved in discussions that could change the basic structure of the ownership?
3. Provide an organization chart showing all key personnel, including their titles, to be assigned to this project. This chart must clearly identify the Proposer's employees and those of the subcontractors and should include the functions to be performed by the key personnel. All key personnel include all partners, managers, seniors and other professional staff that will perform work and/or services in this project. Include the following information:
  - a) Name, title, address, telephone number, email address, and role on the County's account
  - b) A brief biography, including:
    - Qualifications and experience
    - Length of service with Proposer
    - Current account responsibilities
    - Relevant client experiences
4. Describe Proposer's past performance and experience, specifically for groups with over 10,000 employees.
5. Confirm that Proposer has been licensed to transact insurance and administrative products similar to those requested herein, for at least five (5) years in the State of Florida.
6. List the names and addresses of all major first tier subcontractors or sub-consultants (does not apply to Provider Network), and describe the extent of work to be performed by each first tier subcontractor or sub-consultant. Describe the experience, qualifications and other vital information, including relevant experience on previous similar projects, of the subcontractors who will be assigned to this project.

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7. Confirm that Proposer's subcontractors have been licensed to transact insurance and administrative products similar to those requested herein, for at least five (5) years in the State of Florida.
8. On what date did the Proposer first enroll a group in Florida for coverage and for what type of coverage. (If the Proposer is using a subcontractor(s), please identify which services are subcontracted and when the Proposer's subcontractors enrolled the first group in Florida for coverage and for what type of coverage)?

Type of Coverage	Date
HMO Products	
POS Products	
Select or Limited Network Products	
Self-Funding / Administrative Services Agreement (ASO)	
Pharmacy Benefit Management	
Wellness Program	
Disease Management Program	

9. Provide the enrollment data (including all plans) requested below for the Proposer or Proposer's subcontractor(s):

**a.) National Enrollment**

	1/1/2012	1/1/2013	1/1/2014	1/1/2015
Commercial Enrollment				
Medicare Enrollment				
Medicaid Enrollment				
Wellness/Disease Management Enrollment				
Other Enrollment				
<b>Total Enrollment</b>				

**b.) Florida Enrollment**

	1/1/2012	1/1/2013	1/1/2014	1/1/2015
Commercial Enrollment				
Medicare Enrollment				
Medicaid Enrollment				
Wellness/Disease Management Enrollment				
Other Enrollment				
<b>Total Enrollment</b>				

**c.) South Florida (Miami-Dade, Broward, and Palm Beach Counties) Enrollment**

	1/1/2012	1/1/2013	1/1/2014	1/1/2015
Commercial Enrollment				
Medicare Enrollment				
Medicaid Enrollment				
Wellness/Disease Management Enrollment				
Other Enrollment				
<b>Total Enrollment</b>				

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## d.) Miami-Dade County Enrollment

	1/1/2012	1/1/2013	1/1/2014	1/1/2015
Commercial Enrollment				
Medicare Enrollment				
Medicaid Enrollment				
Wellness/Disease Management Enrollment				
Other Enrollment				
<b>Total Enrollment</b>				

10. What percent of the Proposer's Florida enrollment in 2014 and 2015 is from public sector clients? What percentage is fully-insured vs. self-funded?

<u>Medical Florida Enrollment</u>	2015 Total Enrollment	2014 % of Public Sector	2015 % of Public Sector	2015 % of Fully-Insured	2015 % of Self-Funded
Commercial Enrollment					
Medicare Enrollment					
Medicaid Enrollment					
Other Enrollment					
<b>Total Enrollment</b>					

<u>Wellness/Disease Management Florida Enrollment</u>	Total Enrollment	2014 % of Public Sector	2015 % of Public Sector
Wellness Enrollment			
Disease Management Enrollment			
<b>Total Enrollment</b>			

11. List all contracts which the Proposer has performed for Miami-Dade County. The County will review all contracts the Proposer has performed for the County in accordance with Section 2-8.1(g) of the Miami-Dade County Code, which requires that "a Bidder's or Proposer's past performance on County Contracts be considered in the selection of Consultants and Contractors for future County Contracts." As such the Proposer must list and describe all work performed for Miami-Dade County and include for each program: (i) name of the County Department which administers or administered the contract, (ii) description of work, (iii) total dollar value of the contract, (iv) dates covering the term of the contract, (v) County contact person and phone number, (vi) statement of whether Proposer was the prime contractor or subcontractor, and (vii) the results of the program.
12. Provide references for the Proposer's five (5) largest self-funded clients (government preferred that include PBM and wellness/disease management programs), by enrollment, for South Florida (Miami-Dade, Broward, and Palm Beach Counties), Florida or Nationally using the following format. If the Proposer is using subcontractors for PBM services and/or wellness/disease management programs, please include three (3) additional references from the subcontractor.

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Employer Name	Total Number of Employees in South Florida	Number of Employees Enrolled in Proposer's Plan(s)	Date Services Commenced	Contact Person	Address	Phone Number	Email Address
1.							
2.							
3.							
4.							
5.							

13. Provide information for the Proposer's three (3) largest self-funded (government preferred that include PBM, wellness/disease management programs) South Florida (Miami-Dade, Broward, and Palm Beach Counties), Florida or National clients who have terminated the Proposer's plan(s) during the past 24 months using the following format. If the Proposer is using subcontractors for PBM services and/or wellness/disease management programs, please include two (2) additional terminated references from the subcontractor.

Employer Name	Total Number of Employees in South Florida	Date Services Terminated	Reason for Termination	Contact Person	Address	Phone Number	Email Address
1.							
2.							
3.							

14. Provide NCQA, JCAHO, AAA and/or any other accreditation status that applies to the Medical, PBM, Wellness/Disease Management Programs and/or Behavioral Health Program the Proposer is proposing. Provide a copy of the Proposer's accreditation letter(s) and/or the Proposer's subcontractors' accreditation letter(s).

15. Detail any mergers/acquisitions and outcomes (Medical, PBM, Wellness and/or Disease Management) involving the Proposer, which have occurred in the last 12-month period, and any which are planned for the next 12 to 24 months.

16. Is the Proposer's organization currently in compliance with Florida Office of Insurance Regulation profitability and reserve requirements? Yes \_\_\_ No \_\_\_ If no, has the Proposer been required to submit a Corrective Action Plan (CAP)? Yes \_\_\_ No \_\_\_ If yes, attach a copy of the CAP.

17. Has the Proposer had a negative audit finding during a client audit in the past five (5) years? Yes \_\_\_ No \_\_\_ If yes, please summarize findings and resolution. Has the Proposer's organization had to reimburse a client in the past five (5) years as a result of the audit findings? Yes \_\_\_ No \_\_\_ If yes, how much was reimbursed and for what reasons?

18. What was Proposer's client/member retention rate, as a percentage for 2015? 2014?

19. Does Proposer plan on major changes or upgrades to Proposer's administrative system or the platform (Medical, PBM, Wellness and/or Disease Management) Proposer is proposing for the County in the next 24 months? Yes \_\_\_ No \_\_\_ If yes, please explain.

20. Describe the minimum qualifications required for Clinical Case Managers and Utilization Management staff?

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21. Identify the medical staff and/or advisory board who are responsible for reviewing Proposer's programs (Medical, PBM, Wellness, and Disease Management).
22. List the percentage of Proposer's Wellness and Disease Management Programs' clients by size and percentage of overall client base:

Population Size	Number of Clients	% of Client Base
Less than 1,000 employees		%
1,000 – 1,500 employees		%
1,501 – 5,000 employees		%
5,001 – 10,000 employees		%
10,000 + employees		%
<b>TOTAL</b>		<b>100%</b>

23. Show the Proposer's client growth base over the past five (5) years specific to the Wellness and Disease Management Programs:

	2011	2012	2013	2014	2015
<b>Number of Clients</b>					

24. Describe the audit controls that the Proposer has in place such as SAS-70 certified; SSAE-16 certified.
25. Considering the expanding PBM service market today, what differentiates the Proposer from other PBMs?
26. Is the Proposer or any of its subcontractors' owned or controlled by any other organization (Medical, PBM and/or Wellness/Disease Management)? Yes \_\_\_ No \_\_\_ If yes, please explain this relationship.
27. Are any drug manufacturers, distributors, or PBMs in an ownership, day-to-day management, or board of director position with the Proposer.
28. What company/individuals maintain equity in the Proposer's PBM?
29. How many full time employees (broken down by Medical and PBM) work for the Proposer's company? Identify how many Pharmacists, and how many of the Pharmacists are PharmD's.
30. Is the Proposer's Program (Medical and/or PBM) for-profit or not-for-profit? If not-for-profit, under which IRS code does the Proposer operate?
31. Is the County held harmless for negligence on the part of the participating PBM? Yes \_\_\_ No \_\_\_ If no, please explain.
32. Is the Proposer's PBM or any part of the Proposer's PBM in the process of being sold, merged or disbanded? Yes \_\_\_ No \_\_\_ If yes, please explain.
33. Does the Proposer's PBM carry an Errors & Omissions policy? Yes \_\_\_ No \_\_\_ Please attach a copy of the face sheet.
  - If yes, who is the carrier and what is the expiration date of the policy?
  - What are the policy limits and deductible?
  - Is the contract a claims-made policy?

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34. Does the Proposer carry a comprehensive general liability policy? Yes \_\_\_ No \_\_\_ Please attach a copy of the policy face sheet.
- If yes, who is the carrier and what is the expiration date?
  - What are the policy limits and deductible?
35. Does the Proposer or any of its subcontractors' carry a fidelity bond? Yes \_\_\_ No \_\_\_ Please attach a copy of the policy face sheet.
- If yes, who is the underwriter?
  - What is the expiration date of the policy?
  - What are the limits and coverage for the policy?
  - What is the deductible?
  - What are the co-annual aggregate funds held for the County?
36. Have claims been made against any of these policies within the past two years? Yes \_\_\_ No \_\_\_ If yes, what types of claims have been made against the policies?
37. Does the Proposer own or outsource the Proposer's specialty pharmacy? Own \_\_\_ Outsource \_\_\_
38. If the Proposer owns its own specialty pharmacy, what is the name of the specialty pharmacy and where is it located?
39. Provide a brief overview of Proposer's account management team who would be involved in the Disease Management/Wellness Programs.
40. Is a specific account management team assigned to the County? Yes \_\_\_ No \_\_\_ Please describe the role of each member of the dedicated account management team and where they are located. Who is the key primary point of contact for the County?

### Proposed Plan Design, Network, Disruption, Provider Reimbursement, Prescription Drug Benefits, Wellness and Disease Management Programs

41. Confirm Proposer can administer all core benefit options as outlined in **Attachment 5 – Plan Design Worksheets** and further described in **Attachment 2 – Summary of Benefits and Coverage (SOBC) Handbook, by completing and attaching Attachment 5, Plan Design Worksheets.** Provide any deviations within Attachment 5 to the core benefit option covered services, limitations/exclusions and system limitations. Failure to disclose deviations that contribute to additional claims cost may result in the selected Proposer being financially liable for the additional claims cost.
42. At a minimum, address the following items including any limitations, exclusions and system limitations should the County implement any changes to the Plan Design of benefits such as:
- Change in copays for PCP and/or Specialist
  - Change in copays/coinsurance for Hospitals, Emergency Room, Diagnostic Testing, Advanced Imaging
  - Administering different copay/coinsurance by type of facility (i.e., hospital vs. freestanding facility)
  - Administering a tiered-copay/coinsurance by type of network providers
  - Change in copay for prescription drugs and any minimum differential between each tier
  - Administering a select network of facilities/providers for selected plan(s)
  - Administering a select network of pharmacies for selected plan(s)
  - Multiple premium equivalents and contributions for HMO/POS plans based on bargaining unit

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43. At a minimum, address the following items including any limitations, exclusions, network and/or system limitations should the County elect to:
- Carve out Wellness and Disease Management Programs and data sharing between vendors
  - Carve out PBM services and data sharing between vendors
  - Develop a pilot program and direct contracting with local hospital systems and data sharing between vendors
  - Select facilities/provider networks – based on pricing and quality
  - Select/specialty pharmacy networks
  - Carve out advanced imaging services and data sharing between vendors
  - Work with vendors that conduct reviews and develop pricing tools for complete transparency of services and providers pricing
  - Develop a pilot program(s) specifically to and for the County population, to improve chronic conditions, wellness, etc.
  - Ability to provide reporting and justification on the return on investment for the Wellness and Disease Management Programs
44. Describe, in detail, the Proposer's out-of-area coverage for traveling members, both within and outside the United States. Describe the Proposer's capabilities for negotiating fees with out-of-area providers and the cost for negotiating such fees (please provide a percentage or dollar amount for such services).
45. Does the Proposer's plan cover members that utilize services offered through a walk-in facility such as those located in a retail environment? Yes \_\_\_ No \_\_\_ If yes, are there any limitations? If an employee is in an HMO plan and is outside of the service area and chooses to use a walk-in facility or urgent care instead of the emergency room, would this be covered as an in-network benefit? Yes \_\_\_ No \_\_\_ If yes, are there any limitations?

### Behavioral Health/Employee Support Services (ESS)

46. Provide a complete listing of Employee Support Services (ESS) included in the Proposer's proposal for both internal and external services. Refer to [http://www.miamidade.gov/assistance/employee\\_benefits.asp](http://www.miamidade.gov/assistance/employee_benefits.asp) for details regarding the ESS program.
47. Provide a complete listing of all limitations and exclusions to the Behavioral Health/Substance Abuse Programs.
48. Provide a description of any outreach programs used to identify special-needs groups (i.e., women's health, depression, anxiety, domestic violence, substance abuse, etc.).
49. Will the Proposer allow ESS to be provided by the County directly, or another firm, at the County's discretion?  
Yes \_\_\_ No \_\_\_
50. What is the ratio of clinical staff to members (MD, PhD, LCSW, LMFT, LMHC and ARNP)?
51. Describe the types of illness/diagnoses the case management program supports.
52. Will the County members have access to 24-hour crisis intervention services or 24-hour nurse on duty services? Yes \_\_\_ No \_\_\_ If no, what are the hours?
53. Does the Proposer's case management program provide patient-specific information back to the patient's Primary Care Physician? Yes \_\_\_ No \_\_\_

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- 54. Describe the Proposer's procedures and processes for integration of the County's internal ESS. Can the County's ESS directly refer a member to a Behavioral Health/Substance Abuse care provider? Yes \_\_\_ No \_\_\_ If no, describe the process for the County's ESS to obtain authorization for services.
- 55. Will the Proposer provide education and educational materials to facilities/providers and the County's employees regarding available Behavioral Health/Substance Abuse Programs? Yes \_\_\_ No \_\_\_ If yes, describe.
- 56. How would a member access non-life threatening Behavioral Health? How would a member access emergency care or psychiatric evaluations?
- 57. How do members access services after hours and weekends? What percentages of the Proposer's providers, by provider type, (MD, PhD, LCSW, LMFT, LMHC and ARNP) offer evening and weekend access?

Type of Provider	% with Evening Hours	% with Weekend Hours
MD		
PhD		
LCSW		
LMFT		
LMHC		
ARNP		

- 58. Describe the procedures that the County members will follow to obtain an appointment to access needed care.
- 59. Under what circumstances and how frequently are new Behavioral Health/Substance Abuse network providers added to the network? Is Proposer willing to add currently highly utilized providers that are not in the Proposer's network today? Yes \_\_\_ No \_\_\_
- 60. How would transition of care be handled for members currently under Behavioral Health/Substance Abuse care with a provider that is not in the Proposer's existing network, including timeframes? How would transition of care be handled if a provider is terminated from the Proposer's network during the course of treatment?
- 61. How many visits are included in the initial authorization for ESS? How long are these authorizations valid?
- 62. Are the "V codes" (i.e., marriage/couples/family counseling) covered? Yes \_\_\_ No \_\_\_ Do they require an ESS referral in order to be covered? Yes \_\_\_ No \_\_\_
- 63. Describe detoxification services for alcohol and other substances.
- 64. Does this service include ambulatory detoxification through MDs? Yes \_\_\_ No \_\_\_
- 65. Does Proposer have a network management/provider services department that specifically assists with Behavioral Health/Substance Abuse provider issues? Yes \_\_\_ No \_\_\_
- 66. List the Proposer's and/or Proposer's subcontractor's Behavioral Health/Substance Abuse facilities under contract in South Florida (Miami-Dade, Broward, and Palm Beach Counties).

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Specialty	Facility Name	Location
<b>Behavioral/Mental Health Facilities</b>		
Inpatient		
Intensive Outpatient		
<b>Substance Abuse Facilities</b>		
Inpatient		
Intensive Outpatient		
<b>Residential Treatment Facilities</b>		

67. Does Proposer have an arrangement with any providers to accommodate Public Safety Personnel (e.g., separate waiting room)? Yes \_\_\_ No \_\_\_

68. Provide the number of Behavioral Health professionals (broken down by MD, PhD, LCSW, LMFT, LMHC and ARNP) included in Proposer's South Florida (Miami-Dade, Broward, and Palm Beach Counties) network.

Provider Type	Miami-Dade	Broward	Palm Beach
ARNP			
LCSW			
LMFT			
LMHC			
MD			
PhD			

69. What was the turnover rate of Proposer's **Behavioral Health/Substance Abuse** network in 2013, 2014, and 2015? Break down the turnover rate by MD, PhD, LCSW, LMFT, LMHC and ARNP for each year.

	2013	2014	2015 YTD
ARNP			
LCSW			
LMFT			
LMHC			
MD			
PhD			

70. What percentage of Proposer's contract physicians are board certified in Psychiatry for 2015? \_\_\_\_\_ %.

71. Provide the number of Proposer's encounters for South Florida (Miami-Dade, Broward, and Palm Beach Counties), for **ESS** in 2012, 2013, and 2014. Use chart below.

Employee Assistance Program	2012	2013	2014
Visits/1,000 lives			
Percent of covered lives that sought services			
Average number of visits per ESS participant			

72. Where is the Proposer's clinical staff located for Behavioral Health/Substance Abuse and ESS services?

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## Plan Network – Medical

73. If providers will not accept negotiated rates as payment in full, does the Proposer charge to negotiate acceptable rates for these providers? Yes \_\_\_ No \_\_\_ If yes, what are the fees as a percentage or flat dollar amount for these negotiation services.
74. Does the Proposer have special arrangements in place with any provider(s) to have work-site visits performed by physicians or nurse practitioners? Yes \_\_\_ No \_\_\_ If yes, what types of services can be performed at the County's locations?
75. Has the Proposer changed the size or structure of either the primary care or specialty care network for Miami-Dade, Broward, or Palm Beach Counties during the past 12 months? Yes \_\_\_ No \_\_\_ If yes, explain.
76. Complete the following GeoAccess summary for the County employees. The description of the census file layout and census is included in Attachment 1. The Proposer's study should include a summary report for each of the items listed below. Each summary should indicate the total number and percentage of employees with access by zip code and by county for all networks that the Proposer is proposing. Please include the following GeoAccess Reports:
- Number and percentage of employees with two adult Primary Care Physicians (Family Practice, General Practice, Internists) within five miles of the employee's zip code.
  - Number and percentage of employees with two Pediatricians within five miles of the employee's zip code.
  - Number and percentage of employees with two OB/GYNs within five miles of the employee's zip code.
  - Number and percentage of employees with one Urgent Care and Emergency Room within 10 miles.

County	Number of Eligible Employees			PCP - %			PED - %			OB/GYN - %			Urgent Care and Emergency Room		
	HMO	POS	Select	Ees w/ 2 PCPs w/in 5 miles			Ees w/ 2 PED w/in 5 miles			Ees w/ 2 OB/GYN w/in 5 miles			Ees w/ 1 UR/ER within 10 miles		
	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select
Miami-Dade															
Broward															
Palm Beach															

77. Provide an electronic copy ( in a usable Excel format) of the Proposer's most up-to-date provider directory for Miami-Dade, Broward, and Palm Beach Counties including TIN numbers, Name, Address, City, Zip Code, Specialty and Network type for all of the networks that the Proposer is proposing (broken down by each network type). If the Proposer is using different networks, provide all networks proposed and identify each network.
78. Complete and attach **Exhibit 6 - Top Utilized Physicians/Providers** through an electronic copy (in a usable Excel format) of the Proposer's match to the Top 330 currently utilized County's physicians.
79. Have there been any changes to the Proposer's South Florida (Miami-Dade, Broward, and Palm Beach Counties) hospital network in 2013, 2014, or 2015? Yes \_\_\_ No \_\_\_ If yes, explain.
80. Are any of Proposer's local and/or national networks (Medical/PBM) leased/rented or owned by the Proposer? Leased/Rented \_\_\_ Owned \_\_\_ If the network is leased/rented, list the owner and/or name of the network, the service

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area that this leased/rented network covers, and identify any specific issues with the leased/rented network which may have an impact on performance?

81. List what steps the Proposer will take to ensure that the proposed hospital network remains stable within South Florida (Miami-Dade, Broward, and Palm Beach Counties) and nationally.
82. Are there any hospitals in the South Florida (Miami-Dade, Broward, and Palm Beach Counties) area with which the Proposer is not contracted? Yes \_\_\_ No \_\_\_ If yes, list all hospitals.
83. Provide a list of PCPs and Specialists in South Florida (Miami-Dade, Broward, and Palm Beach Counties) that are closed to new members.
84. What is the current percentage of primary care physicians accepting new patients for HMOs in South Florida? Nationally?
85. Will the Proposer's network allow participating dependents to select/access local providers if the dependent resides in another location and if the Proposer has a network available in that location? Yes \_\_\_ No \_\_\_
86. Currently, the High HMOs and Select Network are based on a non-gatekeeper model and the Low HMO is based on a gatekeeper model. Can the Proposer's proposed HMO network track/record a designated Primary Care Physician for both non-gatekeeper and gatekeeper models? Yes \_\_\_ No \_\_\_ Are there any providers under the gatekeeper model that are allowed direct access to network specialists? Yes \_\_\_ No \_\_\_ If yes, include which specialists will members in the Low HMO have direct access to?
87. Is member satisfaction information linked to physician compensation? Yes \_\_\_ No \_\_\_ If yes, describe how?
88. Are all hospital-based physicians (e.g., emergency, pathology, anesthesia and radiology) affiliated with network hospitals contracted? Yes \_\_\_ No \_\_\_ If no, list any hospital physician group(s) not contracted. Please include the hospital affiliation. Are there any circumstances where a member can be balanced billed by a provider? Yes \_\_\_ No \_\_\_ If yes, please describe. How are hospital-based physicians reimbursed for services? If these providers will not accept negotiated rates as payment in full, does the Proposer's firm charge to negotiate acceptable rates for these providers? Yes \_\_\_ No \_\_\_ If yes, what are the fees as a percentage or flat dollar amount for these negotiation services.
89. Indicate the Proposer's contract status for the Proposer's top ten hospital providers (by number of admissions) as well as the Proposer's top ten physician/physician group providers (by number of encounters) broken down by **Miami-Dade County, Broward County and Palm Beach County**. Indicate the current contract status and the contract's expiration date. If these differ by networks proposed, please complete for each network proposed.

## Miami-Dade County Only - HMO

	Hospital	Contract Status	Contract Expiration Date	Date of Last Contract Change		Physicians/Physician Group	Contract Status	Contract Expiration Date	Date of Last Contract Change
1					1				
2					2				
3					3				

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4					4				
5					5				
6					6				
7					7				
8					8				
9					9				
10					10				

**Miami-Dade County Only - POS**

	Hospital	Contract Status	Contract Expiration Date	Date of Last Contract Change		Physicians/ Physician Group	Contract Status	Contract Expiration Date	Date of Last Contract Change
1					1				
2					2				
3					3				
4					4				
5					5				
6					6				
7					7				
8					8				
9					9				
10					10				

**Broward County Only - HMO**

	Hospital	Contract Status	Contract Expiration Date	Date of Last Contract Change		Physicians/ Physician Group	Contract Status	Contract Expiration Date	Date of Last Contract Change
1					1				
2					2				
3					3				
4					4				
5					5				
6					6				
7					7				
8					8				
9					9				
10					10				

**Broward County Only - POS**

	Hospital	Contract Status	Contract Expiration Date	Date of Last Contract		Physicians/ Physician Group	Contract Status	Contract Expiration Date	Date of Last Contract

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			Change				Change
1				1			
2				2			
3				3			
4				4			
5				5			
6				6			
7				7			
8				8			
9				9			
10				10			

Palm Beach County Only - HMO

	Hospital	Contract Status	Contract Expiration Date	Date of Last Contract Change		Physicians/Physician Group	Contract Status	Contract Expiration Date	Date of Last Contract Change
1					1				
2					2				
3					3				
4					4				
5					5				
6					6				
7					7				
8					8				
9					9				
10					10				

Palm Beach County Only - POS

	Hospital	Contract Status	Contract Expiration Date	Date of Last Contract Change		Physicians/Physician Group	Contract Status	Contract Expiration Date	Date of Last Contract Change
1					1				
2					2				
3					3				
4					4				
5					5				
6					6				
7					7				
8					8				
9					9				
10					10				

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90. Complete the following table for Miami-Dade, Broward, and Palm Beach Counties. Use the Proposer's current provider panel. (Use actual number of providers not offices).

Provider Type	Total Providers					
	Miami-Dade County		Broward County		Palm Beach County	
	HMO	POS	HMO	POS	HMO	POS
Allergy & Asthma						
Cardiologists						
Cardiovascular Surgeons						
Chiropractors						
Dermatologists						
Endocrinologists						
ENT						
Gastroenterologists						
General Surgeons						
Geriatricians						
Hematologists						
HIV/AIDS Physicians that specialize in HIV/AIDS treatment						
Infectious Disease						
Neurologists						
Neurosurgeons						
Non-OB Gynecologists						
Obstetrician/Gynecologists						
Oncologists						
Ophthalmologists						
Orthopedic Surgeons						
Pediatricians						
Podiatrists						
Primary Care Physician						
Pulmonologists						
Rheumatologists						
Urologist						

91. Complete the following tables for Miami-Dade, Broward, and Palm Beach Counties for the Proposer's HMO and POS networks.

**HMO Network**

County	Number of PCPs	Number of Specialty Physicians	Percentage of PCPs Accepting New Patients	Percentage of Specialty Physicians Accepting New Patients	Percentage of Physicians Board Certified or Board-eligible
Miami-Dade					
Broward					
Palm Beach					

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County	Number of Acute Care Hospitals	Number of Urgent Care Facilities	Number of Hospitals Offering Tertiary Care	Number of Hospitals Offering Inpatient Behavioral Health Care	Number of Lab Facilities	Number of Home Health Care Agencies	Number of Pharmacies
Miami-Dade							
Broward							
Palm Beach							

## POS Network

County	Number of PCPs	Number of Specialty Physicians	Percentage of PCPs Accepting New Patients	Percentage of Specialty Physicians Accepting New Patients	Percentage of Physicians Board Certified or Board-eligible
Miami-Dade					
Broward					
Palm Beach					

County	Number of Acute Care Hospitals	Number of Urgent Care Facilities	Number of Hospitals Offering Tertiary Care	Number of Hospitals Offering Inpatient Behavioral Health Care	Number of Lab Facilities	Number of Home Health Care Agencies	Number of Pharmacies
Miami-Dade							
Broward							
Palm Beach							

92. Is the Proposer willing to contract with physicians not in the Proposer's network who are currently contracted with AvMed? Yes \_\_\_ No \_\_\_ If yes, is Proposer willing to place a performance guarantee around the contracting efforts? Yes \_\_\_ No \_\_\_ If yes, explain the performance guarantee and any limitations/restrictions.
93. If the Proposer's contracted network of providers extends outside of South Florida (Miami-Dade, Broward, and Palm Beach Counties), please describe the geographical boundaries (i.e., Florida, National, etc.) the County members have access to. Describe any authorization requirements for covered services (non-urgent or emergency services) received outside of South Florida area? Please describe any authorization requirements for covered services (non-urgent or emergency services) received outside of the State of Florida.
94. Provide the Proposer's physician turnover rates for South Florida (Miami-Dade, Broward, and Palm Beach) for 2012, 2013, and 2014. Complete the table using the number of physicians who terminated, separated by a backslash with the total physician count in that specialty. For example, if five (5) Adult Primary Care physicians terminated in total out of a total 200, show 5/200.

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Provider Type	2012		2013		2014	
	Total Terminations	Voluntary Terminations	Total Terminations	Voluntary Terminations	Total Terminations	Voluntary Terminations
Allergy & Asthma						
Cardiologists						
Cardiovascular Surgeons						
Chiropractors						
Dermatologists						
Endocrinologists						
ENT						
Gastroenterologists						
General Surgeons						
Geriatricians						
Hematologists						
HIV/AIDS Physicians that specialize in HIV/AIDS treatment						
Infectious Disease						
Neurologists						
Neurosurgeons						
Non-OB Gynecologists						
Obstetrician/Gynecologists						
Oncologists						
Ophthalmologists						
Orthopedic Surgeons						
Pediatricians						
Podiatrists						
Primary Care						
Pulmonologists						
Rheumatologists						
Urologists						

95. If covered services are not available within the contracted network, explain how members obtain necessary services?
96. What fee schedule does the Proposer use for out-of-network benefits on the POS plan? Can the Proposer administer alternate fee schedules upon the County's request? Yes \_\_\_ No \_\_\_
97. What are the Proposer's access standards for the following appointment types? Do they differ by plan type? Yes \_\_\_ No \_\_\_

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Appointment Type	Wait Time	
	HMO	POS
Initial Patient Visit		
Established Patient – Routine Visit		
Annual Physical Exams		
Urgently Needed Care		
Emergency Services and Care		

98. How and when does the Proposer audit the Proposer's network to determine if the access standards are met? Provide a copy of the Proposer's most recent report.
99. Are PCP and Specialist contracts evergreen? Yes \_\_\_ No \_\_\_ If no, what are the termination requirements within the Proposer's provider contracts as far as timeframes and notification?
100. What provisions are made for transition of care, for Medical services, if a provider is terminated by the Proposer's plan? If the provider terminates the contract? Will ongoing services be treated as in-network? Yes \_\_\_ No \_\_\_ If yes, for how long?
101. What percentage of the Proposer's network physician's offer expanded office hours? How is this information communicated to members?

Type of Provider	% with Evening Hours	% with Weekend Hours
Primary Care Physician		
Pediatricians		
OB/GYN		
Specialists		

102. Is the Proposer's HMO network national, regional or local? National \_\_\_ Regional \_\_\_ Local \_\_\_ If an employee, dependent (including dependent students) or retiree is located outside of South Florida and the Proposer has a regional/national HMO network, can members elect to remain in the HMO plans and utilize the network within their location? Yes \_\_\_ No \_\_\_ Does the Proposer have any programs specific for dependent students that are enrolled in the HMO option? Yes \_\_\_ No \_\_\_ If yes, describe in detail, the out-of-area coverage for dependent students attending school out of area. Include the Proposer's procedures for emergency care, as well as follow-up visits.
103. Does the Proposer have a network in the following areas where the County has a high concentration of college dependents? **Please include in an electronic Excel format, the directories and providers available in these areas.**

Daytona Beach	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gainesville, Florida	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tallahassee, Florida	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Orlando, Florida	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tampa, Florida	<input type="checkbox"/> Yes	<input type="checkbox"/> No

104. Provide the number of contracted ancillary facilities/locations by plan type in each South Florida area (Miami-Dade, Broward, and Palm Beach):

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**HMO**

Provider Type	Miami-Dade	Broward	Palm Beach
Ambulatory Surgery Centers			
Bone Density Testing			
Convenient Care Clinics/Retail Clinics)			
DME Providers			
Home Health Care Agencies			
Hospice Agencies			
Hospice Facilities			
Mammogram Facilities			
Occupational Therapists			
Outpatient Laboratories			
Physical Therapists			
Radiology Centers			
Rehabilitation Facilities (Inpatient)			
Skilled Nursing Facilities			
Speech Therapists			
Urgent Care Facilities			

**POS**

Provider Type	Miami-Dade	Broward	Palm Beach
Ambulatory Surgery Centers			
Bone Density Testing			
Convenient Care Clinics/Retail Clinics			
DME Providers			
Home Health Care Agencies			
Hospice Agencies			
Hospice Facilities			
Mammogram Facilities			
Occupational Therapists			
Outpatient Laboratories			

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Physical Therapists			
Radiology Centers			
Rehabilitation Facilities (Inpatient)			
Skilled Nursing Facilities			
Speech Therapists			
Urgent Care Facilities			

105. Does the Proposer offer a high quality/low cost network of hospitals and physicians? Provide the quality and cost indicators employed to designate high-quality hospitals/physicians.
106. Can Proposer administer the County's custom Select Network program with local County's hospitals? Yes \_\_\_ No \_\_\_  
Are there any limitations? Yes \_\_\_ No \_\_\_ If yes, explain the limitations.
107. Does Proposer agree not to prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to a member or insured of the member or beneficiaries of any self-insured health coverage arrangement administered by the County? Yes \_\_\_ No \_\_\_ At the County's request, is Proposer willing to disclose actual Provider/Facility contracts including full details? Yes \_\_\_ No \_\_\_ Identify any limitations, if applicable.
108. The County intends to exclude claims payment for "Never Events" (Never Events are events that should not have occurred (i.e., the wrong leg being removed) in the future and expects for members to be held harmless. Do all of the Proposer's contracts include language to address non-payment and hold harmless for such events? Yes \_\_\_ No \_\_\_
109. How does each hospital report and address "Never Events" as described by the National Quality Forum (NQF) and how does the health plan oversee the protocol?
110. Complete and attach **Exhibit 1 - CPT Code Analysis**. (The rates should be based on average reimbursements for South Florida (Miami-Dade, Broward, and Palm Beach Counties) providers, NOT statewide provider averages. Use reimbursement rates as of January 1, 2015.
111. Complete and attach both **Exhibit 2 - Medical Claims Re-pricing Analysis** and **Exhibit 3 - Pharmacy Claims Re-pricing Analysis**. Use Proposer's 2014 contracted rates.
112. If Proposer's plan has capitated charges (i.e., behavioral health, labs, chiropractic, etc.) built into Proposer's claim and expenses charges, disclose all such charges, fees and detail what they cover. Please be specific in the amount for each item.
113. Indicate if Proposer has a "Centers of Excellence" program for each of the following and list Proposer's designated facilities for each:

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Facility(ies):	In Network or Out of Network
Transplants	<input type="checkbox"/>	<input type="checkbox"/>		
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>		
Neonatal	<input type="checkbox"/>	<input type="checkbox"/>		
Bariatric	<input type="checkbox"/>	<input type="checkbox"/>		

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Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Facility(ies): _____
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- 114. Describe policies regarding Proposer's "Centers of Excellence" program. Is the program voluntary or mandatory?  
Voluntary \_\_\_ Mandatory \_\_\_
- 115. Provide the criteria used for obtaining the designation and the crediting body for Proposer's "Centers of Excellence".
- 116. Does Proposer use incentives to encourage members to seek out minimally invasive surgical providers (MIP) within their network? Yes \_\_\_ No \_\_\_ If yes, please explain.
- 117. Will Proposer work with the network providers who deliver the most efficient surgical care? Yes \_\_\_ No \_\_\_ If yes, please explain how.
- 118. Does Proposer offer incentives to network providers to encourage a minimally invasive procedures (MIP) technique over open surgery? Yes \_\_\_ No \_\_\_ If yes, please explain.

## Provider Relations

- 119. Does Proposer have a network management/provider services department that assists with provider issues? Yes \_\_\_ No \_\_\_ Identify the staff members and their respective titles, to be assigned to the County.
- 120. Identify where the network management/provider services' staff that services the Proposer's South Florida network is located.
- 121. Describe how Proposer will communicate with providers the County's schedule of benefits, changes to the schedule of benefits and general administrative policies and procedures specific to the County's Program.
- 122. Describe how Proposer will ensure that providers in Proposer's network refer to network facilities and other network providers.
- 123. Do the hospitals have a whistleblower provision to protect hospital staff who report unsafe work/working conditions? Yes \_\_\_ No \_\_\_ If yes, how many times has it been used and what were the circumstances? Was safety improved and institutionalized? Describe the new protocol and how it is enforced.
- 124. Does Proposer have the ability to set-up, manage and staff onsite clinics for the County employees? Yes \_\_\_ No \_\_\_ If yes, please provide Proposer's capabilities, and abilities to set-up, manage and staff onsite clinics for the County, including Medical, PBM, Wellness and Disease Management services.

## Credentialing

- 125. How often does Proposer conduct onsite visits to physicians to explain contracts and contract changes?
- 126. Is Proposer's provider credentialing process conducted in-house or delegated to another organization? In-House \_\_\_ Delegated \_\_\_ If delegated, provide the name of the organization and how long the functions have been delegated.
- 127. Do credentialing policies and procedures meet accreditation standards? Yes \_\_\_ No \_\_\_ If yes, what accreditation organization?
- 128. How long does it take to credential a new physician? How often does Proposer's Credentialing Committee meet?
- 129. How often does Proposer re-credential network providers? Will new providers be considered at the request of the County?

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130. Between re-credentialing cycles, does Proposer conduct ongoing monitoring of practitioner sanctions, complaints and quality issues? Yes \_\_\_ No \_\_\_ If yes, how often?
131. How many physicians has Proposer terminated from its South Florida (Miami-Dade, Broward, and Palm Beach) network in 2013 and 2014 that failed to maintain credentialing standards? Identify how many have been terminated due to quality assurance reasons.
132. Detail the structure, process and outcome criteria and standards Proposer uses to select physicians, hospitals and other providers for participation in its networks. Provide a list of minimum thresholds for each metric Proposer uses.

**Wellness and Disease Management Programs**

133. Please indicate Proposer's ability to provide integrated wellness, preventive care services and disease management programs as part of an overall approach to providing full healthcare administrative management (either directly or through a subcontractor), as follows:
- Follow-up care and programs to address health risks and prevalent chronic diseases over time, e.g., cardiac risk, diabetes and asthma management programs, etc.
  - Reporting systems to allow year-to-year comparisons and identification of the effects of risk screening, wellness and disease management benefits on total plan costs.
  - Health risk and consumer educational materials.
134. In two pages or less, describe Proposer's Disease Management Program(s). Include details on how Proposer's Disease Management Program(s) remains current based on research and industry trends. Provide sample letters and literature from such programs. In addition, address the following as it relates to Proposer's Disease Management Program:
- Intervention Model. How would Proposer characterize Proposer's program? High reach, low intensity model? A low reach, high-intensity model? A nurse-based program? A technology-based program?
  - Patient identification. What percentages of members are identified for intervention?
    - Through claims
    - Through other programs (case management, wellness coach)
135. Identify how many of the members identified are contacted by a Wellness/Disease Management Program professional. For this question, "contact" is a LIVE attempt to contact a member by a Wellness/Disease Management Program professional either through a phone call to the member or to the member's spouse or the member's physician. If Proposer has other means of contacting members such as automated calls, mailings, text messaging or email blasts, please note them here.
136. Are there additional metrics utilized by the Proposer or industry that are not captured in this section? Yes \_\_\_ No \_\_\_ If yes, include add other information about Proposer's program that, in general, makes Proposer's program stand out among the competition.
137. With regard to specific diseases:
- What diseases does Proposer actively manage?
  - Does Proposer use different interventionists for different disease states?
  - When does Proposer begin to manage a particular disease? For example, does Proposer offer assistance at the time of a cancer diagnosis or during an active course of treatment?

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138. Is Proposer's Disease Management group in house? Yes \_\_\_ No \_\_\_ If no, how do Proposer's subcontractor(s) access patient benefits, eligibility, data, etc.?
139. Describe, in one page or less, how Proposer captures and shares information with its different segments of the clinical model.
140. With regards to "Hand Offs and Overlaps," how does a hand off work? A hand off is when one segment of the clinical model needs to involve another segment of the clinical model? How does case management interact with disease management? Is it possible that more than one segment of the clinical model is "touching" a patient at the same time? If so, how is information shared between segments of the clinical model?
141. In two pages or less, describe Proposer's Wellness Program. Be sure to include the basic nature of the Program, inclusive of the following:
- a. Participation rates x incentives
  - b. Patient identification – What percentage of members are identified for intervention?
  - c. Through claims
  - d. Through other programs (case management, wellness coach)
  - e. Of the patients identified, how many are contacted by a medical management professional? For this question, "contact" is a LIVE attempt to contact a member by a medical management professional either through a phone call to the member or to the member's spouse or the member's physician. If Proposer has other means of contacting members such as automated calls, mailings, text messaging or email blasts, please footnote them here.
  - f. Is there some other metric that is not captured in this section? If so, feel free to add some other information about Proposer's program(s) that, in general, makes Proposer's program(s) stand out among the competition.
142. Complete the chart below for each service Proposer provides (check all that apply). Provide examples of Proposer's resources:

Wellness Services	DELIVERY MODE					OUTSOURCED VENDOR
	Direct Mail	Online	Telephonic	Onsite	Seminars/One-on-One Counseling	Name of Vendor
Health Risk Assessment						
Biometric Screenings						
Diabetic Counseling						
Health Coaching						
Health Education & Awareness Campaigns						
Self-Directed Programs						
Resource Facilitator						
Health Partnerships						
Follow UP Reports						

143. Provide Proposer's Program(s) delivery staffing structure to include number of employees, experience, credentials, education, and role in each area.

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	# of Staff	Average Years of Experience	Required Credentials & Education	Role in Program Delivery
Health Coaches				
Exercise Physiologist				
Registered Dieticians				
Account Management				
Nurse Practitioners/Pas				
Physicians				
Customer Service Representatives				
Wellness On-Site Manager				
Other				

144. Describe enrollment strategies (i.e., opt in, opt out, claims data, etc.).
145. Provide a list of the tools available to program participants (i.e., goal setting activities, interactive tools, action plans, journals, etc.).
146. Describe Proposer's capabilities in managing rewards and incentives. Provide examples of such incentives and corresponding budget.
147. The County currently has minimal incentives to drive participation into Disease Management/Wellness Programs. Describe Proposer's strategy to drive participation and maintain participant engagement. Will Proposer guarantee an ROI? Yes \_\_\_ No \_\_\_ If yes, describe the performance guarantee around the ROI.
148. Indicate participation and completion rates (pre and post) for clients that the Proposer has provided the following type of on-site and online initiatives. Describe the initiatives that were provided.

Onsite Initiatives	Participation Rates	Completion Rates
Walking Programs		
Exercise Programs		
Weight Loss Challenges (Total Weight Loss)		
Nutrition Programs		
Gym/Fitness Center Participation/Encouragement		
Smoking Cessation		

149. Complete the chart below and provide documentation supporting the Proposer's Lifestyle Management Programs (check all that apply). Provide evidence for gender specific education and awareness (i.e., breast care for women, cardiovascular disease for women, prostate for men, etc.).

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	Lifestyle Management Programs - Delivery Mode						
	Mailings	Online	Self-Directed Programs	Telephonic Coaching	Onsite Seminars Lunch and Learns	One-on-One Counseling	Other
Heart Disease							
Diabetes & Diabetic Counseling							
Cholesterol							
Hypertension							
Asthma							
Nutrition							
Fitness & Exercise							
Women's Health							
Men's Health							
Self Care							
Smoking Cessation							
Weight Management							
Stress Management							
Back pain/Ergonomics							
Gaps in Care							
Pregnancy/Prenatal							
Other:							

150. Describe the data sources that Proposer utilizes to identify individuals eligible for Proposer's Disease Management Program (e.g., Medical/Rx claims data, Health Risk Assessment data, Biometric Screening data, other).
151. Which conditions does Proposer target (e.g., Diabetes, Hypertension Hyperlipidemia, etc.)? What is Proposer's ROI for each area targeted? Provide Proposer's block of business ROI for 2014 for each condition that Proposer targeted.
152. Describe Proposer's ability to stratify the population based on risk using factors such as number of conditions (co-morbidities), condition severity, data source (self-reported condition versus abnormal labs or Dx code), and how well the individual is managing their condition.
153. What methodology is used for behavior change?
154. How are network providers made aware of the availability of Proposer's Wellness/Disease Management Program?
155. Are members identified for Disease Management automatically enrolled (requiring them to opt-out if they choose not to participate) or do members identified for Disease Management have to enroll to participate?
156. What forms of intervention are available (e.g., telephonic, on-site, group sessions, electronic platform, etc.)?
157. How many attempts are made to contact a member?

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- 158. If a member is unreachable, what is the process to get in touch with the member?
- 159. If a member gets closed out, how long until they are contacted again or given the option to participate?
- 160. Describe Proposer's capabilities to manage or offer the following (check all that apply):

	SERVICES				OUTSOURCED VENDOR	
	Offer	Manage	Coordinate	Community Partnership	Name of Vendor	Service Not Offered
Onsite Clinic						
Lunch and Learns						
Fitness Center Discounts						
Weight Loss Competitions						
Stress Management (Yoga, Tai Chi, etc.)						
Walking Programs						
Other:						

- 161. What are Proposer's criteria to discharge/dis-enroll a member?
- 162. Provide member attrition rate (member dis-enrolls) in 2014 for each Wellness and Disease Management Program offered.
- 163. Describe the type and number of staff professionals (PA's, LPN's, RN's and Nurse Practitioners) who will be handling the County's members. How is the staff assigned to each case? Describe oversight/supervision provided by physicians.
- 164. Are members' physicians notified of the Disease Management Program's care plan? Yes \_\_\_ No \_\_\_ Progress or lack of progress?
- 165. All members in the Disease Management Program should have a specific nurse manager regardless of whether they are suffering from one or more than one chronic condition. If there are exceptions, explain each.
- 166. How does Proposer measure clinical impact of each Disease Management Program?
- 167. How does Proposer recommend handling transition of care issues? Be specific with respect to pregnancy, hospitalization, prolonged treatment protocols, and chronic/terminal illness. For how long will Proposer authorize non-network care for these conditions?
- 168. Describe Proposer's policies and processes for identifying and paying claims which may be subrogation opportunities.
- 169. How does Proposer's system identify potential Coordination of Benefits (COB) claim situations and maintain COB information on file?

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## PBM Plan Benefits

The following questions are specific to the Proposer's internal or subcontracted PBM that is being proposed to the County as part of this RFP.

170. Confirm availability of the following plan design elements. Please specify if any additional fees apply in the Proposer's response below:

- Calendar year deductible?
- Calendar year deductible followed by percentage co-pay?
- Calendar year deductible followed by percentage co-pay with an out-of-pocket maximum (single and family)?
- Flat dollar co-pay generic, percentage co-pay brand?
- Over the Counter Drugs coverage as tier one or tier two?
- Co-payment based on Lifestyle changes? i.e. cholesterol levels, weight loss, etc.
- Three-tier co-pay: flat dollar for generic, flat amount or percentage for multi-source, flat amount or percentage for single source?
- The greater of a flat dollar amount or percentage co-pay (e.g., greater of \$10 or 20%)?
- Cash and carry reimbursement (managed indemnity)?
- 100% member co-pay at the point of sale (discount card)?
- Four tier program with specialty Rx?
- Fifth tier program for lifestyle drugs?
- Separate deductibles within therapy classes?
- Co-payment based on quantity for certain products (i.e., bottles of Insulin, pain medications, PRN medications or any other medication where the dose may vary each day)?
- Mail order co-pays at 2X retail, 2.5X retail and 3X-retail available? Which copay option does the Proposer recommend and why? What would be the cost avoidance/savings, if the County changed to a different mail order copay structure?

171. Explain how out-of network pharmacy claims are processed.

172. Can pharmacies access the Proposer's service representatives 24 hours/day? Yes \_\_\_ No \_\_\_ If no, what hours are available? Is a pharmacist available 24 hours a day? Yes \_\_\_ No \_\_\_ If no, what hours are available? Explain any IVR system and how it works with the pharmacies.

173. Can certain drugs be limited to a specific diagnosis, specific specialty or require pre-authorization or step-therapy? Yes \_\_\_ No \_\_\_ Can certain drugs be limited to certain quantities and certain length of therapy? Yes \_\_\_ No \_\_\_

174. Is the Proposer's pre-authorization process administered in-house or by a third party? In-house \_\_\_ Third Party \_\_\_ Does the Proposer have administrative and clinical pre-authorizations? Yes \_\_\_ No \_\_\_

175. How are the clinical pre-authorizations different? What are the charges for each, if any?

176. Can the Proposer administer plans that include non-Federal Legend (OTC) drugs? Yes \_\_\_ No \_\_\_ Can the Proposer place OTC's on first, second or third tier?

177. Does the Proposer have the ability to provide a (COB) provision? Yes \_\_\_ No \_\_\_ If yes, please explain. Are there any charges for this process? Yes \_\_\_ No \_\_\_ If yes, what are the charges.

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178. If a drug is denied or not covered explain how medical necessity is determined and then managed.
179. What positions do Pharmacists and PharmD's hold in the Proposer? Please be specific. Differentiate clinical, account management and executive positions.
180. Are there any retail chain pharmacies excluded from the Proposer's preferred network? Yes \_\_\_ No \_\_\_ If yes, please list all excluded retail chain pharmacies from Proposer's preferred network. Is there any cost savings for excluding these retail chain pharmacies? Yes \_\_\_ No \_\_\_ If yes, what are the cost savings.
181. Describe the Proposer's support for the Retiree Drug Subsidy (RDS) for the County. As part of the Proposer's response, include comments on the following specific areas:
- Providing data for actuarial certification of credible coverage and evaluation of equivalence to the standard plan.
  - Providing data for periodic reporting to CMS of enrollment data and drug costs.
  - Access to actuarial services for certification of creditable coverage and evaluation of equivalence to the Part D standard plan.
  - Periodic submission of enrollment data and claims cost files to CMS.
  - Annual reconciliation of periodic claims-cost submissions.
182. Does the Proposer have its own mail service prescription drug program? Yes \_\_\_ No \_\_\_ If yes, is it fully integrated with the Proposer's retail network? Yes \_\_\_ No \_\_\_ If no, describe the Proposer's relationship with the mail order operation the Proposer has selected.
183. Does the Proposer subcontract with an outside mail service vendor? Yes \_\_\_ No \_\_\_ If yes, which mail service vendor does the Proposer use and how is mail order integrated with the Proposer's retail program? Is the mail service plan integrated with the Proposer's retail program for utilization review and reporting? Yes \_\_\_ No \_\_\_ Is the mail service plan integrated with the Proposer's retail program and eligible for formulary rebates? Yes \_\_\_ No \_\_\_ At what capacity are the Proposer's mail services? If more than one location, give the capacity at each location.
184. Where are the Proposer's mail service facilities located?
185. What standard usage percentage does the Proposer use for mail order refills? Explain why the Proposer uses that percentage. Can this percentage be specified by the County? Yes \_\_\_ No \_\_\_
186. How does the Proposer determine days' supply on topical products, insulin, PRN medications and any other medication where the dose can vary at each therapy occurrence?
187. What is the standard minimum and maximum days' supply available through the Proposer's mail order program? Can the Proposer fill a 35 day prescription at mail and at retail? Yes \_\_\_ No \_\_\_
188. Does the Proposer support a 90 day at retail program? Yes \_\_\_ No \_\_\_ If yes, please include the Proposer's average pricing for this program including rebates.
189. Describe the Proposer's Specialty Pharmacy Program including its integration with the Proposer's traditional mail and retail programs. How would the Proposer integrate with the County's medical plan?
190. Describe any programs in place or in development to encourage participants to use the mail service option (i.e., target letters, incentive coupons, and direct phone calls).
191. When the last refill of a prescription has been dispensed, what procedures does the Proposer have in place to alert and assist the member in renewing the prescription?
192. How does the Proposer alert a member when a prior authorization is about to expire? How much advance notice is given to the member?
193. Does the Proposer provide compounding services at Mail Order? Yes \_\_\_ No \_\_\_

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194. Does the Proposer permit physicians to directly phone-in prescriptions to the Proposer's facility? Yes \_\_\_ No \_\_\_
195. Does the Proposer use minimum copay logic at mail order? Yes \_\_\_ No \_\_\_ If yes, please describe.
196. What is the Guaranteed Overall Effective Generic Discount the Proposer will offer the County?
197. Describe how the Proposer works with the network pharmacies to increase generic utilization. Describe any incentives or fees paid to the network pharmacies to increase utilization.
198. In a MAC program, explain how DAW-1 and DAW-2 prescriptions are expensed to the plan participant under:
- A mandatory generic program.
  - A non-mandatory generic program.
199. Describe if under any circumstances, the member is penalized if the pharmacy is out of stock of a generic under the Proposer's mandatory generic program? Yes \_\_\_ No \_\_\_ If yes, when?
200. List the Proposer's generic strategy and specific programs to encourage the use of generic medications. Explain how the Proposer anticipates increasing generic fill rates to take advantage of the multiple products going generic over the next three years?
201. Will the Proposer guarantee a generic utilization percentage? Yes \_\_\_ No \_\_\_ What data will the Proposer need to develop a guarantee? How long is the guarantee for?
202. Does the Proposer have a step therapy program to increase generic penetration rates within certain therapy classes? Yes \_\_\_ No \_\_\_ If yes, what classes?
203. How is the Proposer's prescription formulary developed and administered?
204. Are the formularies based on the lowest cost prescriptions available? Yes \_\_\_ No \_\_\_ If no, describe how the financials are calculated into the preferred and non-preferred products.
205. Does the Proposer offer a closed formulary or generic only formulary? Yes \_\_\_ No \_\_\_
206. What types of open or restrictive formularies are available?
207. Do all drug manufacturers whose products are listed as preferred in the Proposer's formulary provide rebates? Yes \_\_\_ No \_\_\_ If yes, what percentage of the preferred products have rebates?
208. Do any non-preferred products get rebates? Yes \_\_\_ No \_\_\_ If yes, what is the percentage?
209. Are there any minimum formulary requirements for the County to participate in rebate payments?
210. Would rebates paid be based on the County's claim volume or on an average derived from the Proposer's entire book of business?
211. Are the rebates guaranteed? Yes \_\_\_ No \_\_\_ If no, is there a minimal guarantee?
212. When is the County's share of the rebates 100%?
213. Is the rebates reconciliation detail, either at the manufacturer level or at the claim level, shared with the County?
214. What percentage of total formulary products has rebates?
215. How are the rebates shared with the County?
- Are the rebate dollars paid to the County via check or are credits given retrospectively or prospectively?
  - Can the Proposer pay rebates at point of service?
  - Does the Proposer have a 100% pass-through?
  - Does the Proposer have a shared rebate program? Please describe.

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- Does the Proposer have a program where the Proposer retains rebates for administrative and or other fees?
  - Does the Proposer have a program where the Proposer retains some of the rebates for an administrative offset and then annually provides a reconciliation and issues remaining rebates to the County at that time?
216. Explain the structure and function of the Proposer's Pharmacy and Therapeutics Committee. How often does the Proposer Pharmacy & Therapy (P&T) Committee meet and how often does a therapy class get reviewed?
217. How does the Proposer report rebates to the County? Are audits available? Yes \_\_\_ No \_\_\_ If yes, how are they completed? Are audits down to the drug level or only to the aggregate rebate level?
218. Does the Proposer have an individual who manages the formulary, and if so what is his/her name and qualifications?
219. How long after plan inception are the first rebate shares paid and in what intervals thereafter? Can rebates be paid quarterly? Yes \_\_\_ No \_\_\_
220. Assuming rebates are paid per unit, are retail and mail prescriptions paid at the same level? Yes \_\_\_ No \_\_\_ If no, explain why.
221. Can specific formularies be developed for the County? Yes \_\_\_ No \_\_\_ If yes, please provide the following information:
- Will this custom formulary affect rebate rates? Yes \_\_\_ No \_\_\_, If yes, explain how?
  - What impact (savings/cost) will a County custom formulary have on the overall claims spend?
  - How does management programs such as step therapy, prior authorization, etc., work with a County custom formulary?
222. Does the Proposer share rebates on specialty (injectable) medications? Yes \_\_\_ No \_\_\_ If yes, please indicate either the number of product rebate contracts or the percentage by dollar volume of specialty products that do receive rebates.
223. Does the Proposer guarantee rebate dollars per claim retail and mail? Yes \_\_\_ No \_\_\_ Rebate dollars per brand claims only or rebates per member per month or any other rebate formula?
224. Does the Proposer accept any rebate administrative fees? Yes \_\_\_ No \_\_\_ If yes, identify the average percentage.
225. Does the Proposer accept any commissions, therapeutic interchange fees, communication fees or any other fees or payments from pharmaceutical companies? Yes \_\_\_ No \_\_\_ If yes, explain.
226. Do all network pharmacies have the same contract rates? Yes \_\_\_ No \_\_\_ If no, explain how contracts are negotiated and developed.
227. Does the Proposer have pass through network pricing available? Yes \_\_\_ No \_\_\_
228. Does the Proposer actively develop custom networks or is there an opportunity to do so in the future? Yes \_\_\_ No \_\_\_ If yes, what is the timeframe to develop a custom network?
229. Can the Proposer manage an in-network and out-of-network plan design for pharmacies? Yes \_\_\_ No \_\_\_ If yes, identify if there are any limitations?
230. What percentage of the Proposer's pharmacy network is online? If not 100%, explain.
231. How many claims does the Proposer process per month? What is the Proposer's capacity?
232. Does the Proposer run Geo-Access models to determine percentage of members within a given radius? Yes \_\_\_ No \_\_\_ What is the standard that are utilized for running the Geo-Access models?
233. In the last year, where data was available, what percent of claims were rejected?

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234. Please give historic data on rejected claims for the last two years (2013 and 2014) by category and give the percentage for each as a percent of all claims submitted.
235. Can the County request a pharmacy be added to the network? Yes \_\_\_ No \_\_\_ If yes, how long does it take to become fully operational where prescriptions can be filled there under the County's plan?
236. What is the mechanism for members to request network pharmacy additions? Is there a phone number?
237. How frequently are pharmacies paid? How are they paid?
238. Are pharmacies paid what the County is billed? Yes \_\_\_ No \_\_\_ If no, what are the pharmacies paid?
239. Does the Proposer re-negotiate pharmacy contracts? Yes \_\_\_ No \_\_\_ How long is the term of a normal PMB contract? How does that new contract affect the County if there is an increase in discounts? Is the Proposer willing to share the terms and conditions of the actual pharmacy contract? Yes \_\_\_ No \_\_\_
240. How does the Proposer manage the quality of services provided by the Proposer's network pharmacies? How does the County report a service issue? How often are pharmacies reviewed? How many pharmacies were removed from the Proposer's network last year and why?
241. Does the Proposer participate in pharmacy withholds? Yes \_\_\_ No \_\_\_ If yes, are copies of pharmacy remittances available for audit?
242. Does the Proposer pay fees or provide reimbursement to any of the following:
- Physicians-Formulary Compliance? Generic prescriptions rate? Other?
  - General agents? Marketing fees, Survey fees?
  - Insurance agents/brokers/consultants? Commissions?
  - Pharmacy consultant service fees?
  - Marketers?
  - Pharmaceutical manufacturers Pharmacies? Other than dispensing fees?
  - Insurers, third party administrators?
  - Switch operators? Envoy, NDC, etc.?
  - Electronic Processors?
- If yes, please explain the fee/reimbursement structure for each of the above.
243. Does the mail order program offer an online method to order and/or refill prescriptions and explain how it functions. Yes \_\_\_ No \_\_\_ Does the program offer email reminders on prescription refills? Yes \_\_\_ No \_\_\_
244. Can members review their preferred drug listing (formulary) on-line? Yes \_\_\_ No \_\_\_
245. Does the member get a comparative list of medications to those they are taking that indicates lower cost alternative products? Does the program show the cost savings for the member? For the plan? Is this available online? Via a letter to member? Via a letter to the physician?
246. Describe any plan design/formulary modeling tools that will be available for use by the County.
247. Please describe all of the Proposer's clinical cost management programs and whether the Proposer includes any of the following:
- Anti-fungal
  - Appropriateness of use

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- Daily Average Consumption
- Gastrointestinal
- Generic Solutions
- Maximum Daily Dose
- Migraine
- NSAIDs
- PAIN medication
- Substance Abuse

248. Does the Proposer provide administrative services for prior authorization as part of the basic package? Yes \_\_\_ No \_\_\_

249. Explain the different prior authorization options available to the County.

250. Provide a list of drugs the Proposer typically recommends for prior authorization, quantity limitations, and step therapy protocols. Can the County customize these prior authorizations, quantity limitations, and step therapy? Yes \_\_\_ No \_\_\_ If yes, describe the County's options.

251. Does the Proposer provide clinical prior authorizations? Yes \_\_\_ No \_\_\_ If yes, is there a charge for this service?

252. Does the Proposer have step therapy programs? Yes \_\_\_ No \_\_\_ Please describe how the program works?

253. Can the Proposer provide a step therapy program within a specific therapy class? Yes \_\_\_ No \_\_\_

254. Are the charges of all DUR programs clearly stated in the cost section of the Proposer's proposal? Yes \_\_\_ No \_\_\_

255. Please provide a copy of the Proposer's service fee agreement(s).

256. Please describe the Proposer's Specialty Pharmacy fulfillment process from start to finish. How does the Proposer manage specialty/injectable drugs? Does the Proposer rent specialty pharmacy services? Yes \_\_\_ No \_\_\_ If yes, who is the Proposer's vendor? How long is the Proposer's contract with that vendor?

257. How does the Proposer access the specialty pharmacy vendor to give and/or receive benefits?

258. Describe how Specialty Pharmacy data is integrated with outpatient prescription data for DUR, benefit design, and other system edits?

259. Complete and attach **Exhibit 5 (in a useable Excel format) – Specialty Prescription Drug List Sample** by providing an injectable drug/specialty drug list in the attached Excel file with the Proposer's recommendations for coverage.

260. What are the hours of operation for dispensing specialty medications? Is the clinical pharmacist or other medical personnel responsible for questions and what are the hours of operation?

261. Can the prior authorizations relating to specialty drugs be customized? Yes \_\_\_ No \_\_\_

262. Describe the level of rebates the County should expect to receive on specialty pharmaceuticals dispensed via the Proposer's specialty pharmacy provider. Are rebates collected and shared on specialty drugs? Yes \_\_\_ No \_\_\_ What is the average percentage rebate for specialty drugs? Does percentage of rebates change if provided through exclusive network?

263. Are biosimilar (generic specialty drugs) subject to a MAC list? Yes \_\_\_ No \_\_\_

264. How many copayment tiers can the Proposer manage for specialty drugs? Identify the Proposer's recommendation and identify the cost impact of these recommendations?

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265. Describe the quality control process of the Proposer's specialty pharmacy operation in the drug and information delivery process.
266. Describe how the Proposer handles international shipments.
267. Describe how the Proposer handles lost shipments.

### Member Services, Quality Assurance, Technology, Medical Management, Claims, Fraud, Disaster Recovery, Account Management, Reporting and Utilization Management, and Implementation

268. Will the Proposer analyze monthly and year-to-date Behavioral Health/Substance Abuse and ESS results for the County and make recommendations to improve cost and utilization trends? Yes \_\_\_ No \_\_\_
269. How does the Proposer measure the overuse of tests, treatments and procedures? How does the Proposer measure the underuse of tests, treatments and procedures?
270. Does Proposer offer members online capabilities or a mobile application? Online \_\_\_ Mobile \_\_\_ If so, what functionality is provided? Please provide snapshots/demo site.
271. A requirement of the Newborn's and Mother's Health Protection Act is that plan sponsors disclose their plans physicians' compensation agreements when the Department of Labor conducts a HIPAA compliance audit. Does Proposer's physician contract with obstetrician incent providers to induce or encourage early discharge relative to maternity hospital stays? Will Proposer divulge physician contract information to the County if such an audit is ordered and the information is required?
272. What cyber-security protocols does Proposer have in place to safeguard and protect patient information from a data breach? Has Proposer had a breach to Proposer's HIPAA data/system in the past 5 years? Yes \_\_\_ No \_\_\_ If yes, please provide details regarding the breach and how it was resolved. Please describe the encryption technology used to protect patient health information.
273. What is Proposer's readmission rate related to surgery?
274. Provide the readmission rates by each of the Proposer's South Florida network hospital for the ten most common admissions.
275. What is the Proposer's infection rate for surgery and for medical care?
276. Are physicians, clinics and/or hospitals rewarded for improving quality performance? Yes \_\_\_ No \_\_\_ If yes, describe in detail, including measures, incentives/rewards and shared savings.
277. Will Proposer provide information directly to members to facilitate provider selections that are cost effective to the Program? Are these solutions web-based? Yes \_\_\_ No \_\_\_ If yes, please explain.
278. Has Proposer demonstrated success (or experience) in working with other employers to improve surgical quality through a focus on minimally invasive procedures (MIP)?
279. What quality and cost data does Proposer make available to members for selecting hospitals, clinics, imaging centers, labs and physicians in Proposer's network for provider comparison? How often is the data updated? How is this data updated and what additional data will be available in 2016 and 2017?

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280. What quality, cost, satisfaction and outcome data/tools are available for both the County and members for selecting in-network providers (i.e., specifically cancer care, orthopedics, maternity, heart disease, behavioral health, pediatrics, emergency care, etc.)? How is this data updated and what additional data will be available in 2016 and 2017?

### Eligibility and Claims Administration

281. What is Proposer's average lag time for claims?

282. Are eligibility and claims administered on the same system? Yes \_\_\_ No \_\_\_ If no, how are these functions integrated?

283. Provide the location where claims and eligibility will be processed for the County.

284. Will the County have a dedicated team for eligibility, claims and customer service? Yes \_\_\_ No \_\_\_ If yes, will they be located on-site or work remotely?

285. Will Proposer provide the County with an eligibility contact person for eligibility file issues and questions? Yes \_\_\_ No \_\_\_ If yes, will the person be on-site or work remotely?

286. What eligibility responsibilities does Proposer expect the County to perform? Describe the options available for electronic transfer of eligibility information, enrollment of new hires, terminations, etc.

287. Are network contracts/fee schedules loaded into Proposer's claims administration system or must claims be submitted elsewhere for re-pricing?

288. Can Proposer's claims adjudication process block J Codes (except for neoplastic drugs from oncologists/hematologists) from processing? Yes \_\_\_ No \_\_\_ How does Proposer's organization propose to educate Proposer's network on this process?

289. What percentages of Proposer's claims are submitted electronically by facilities? By physicians?

290. What percentages of Proposer's claims submitted by facilities are auto adjudicated? \_\_\_\_\_% By physicians? \_\_\_\_\_%

291. Provide details on the system edits that are contained in Proposer's claims processing system that assist examiners in accurately processing claims. Indicate how Proposer's system adjusts for coding errors.

292. Describe Proposer's explanation of benefits (EOB) process for HMO, Select, and POS and if these are available hard copy and/or online. Is there any flexibility? What information is included on the EOB statements? What electronic functionality is available (e.g., emailed via secure link, etc.)?

293. Is Proposer willing to accept full delegation of fiduciary responsibility with respect to claim adjudication under Proposer's ASO contract? Yes \_\_\_ No \_\_\_

294. What access will the County auditors and/or third-party have to medical claims, pharmacy claims and administrative data necessary to complete an annual audit either onsite or electronically? Describe any limitations.

295. Is Proposer willing to allow access to a full claims audit, at Proposer's expense, in the event of significant performance issues? Yes \_\_\_ No \_\_\_

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296. Are in and out-of-network claims paid by the same claims system? Yes \_\_\_ No \_\_\_ If two different claims systems are used, describe each and specify how the systems interact.

297. Provide details regarding Proposer's claims processing performance for the most recent year for HMO, POS and Select plans.

	Target Goal	Actual Performance
Clean claims processed within 10 days	% within days	% within days
Clean claims processed within 30 days	% within days	% within days
Average days turnaround	_____ Business Days	_____ Business Days
Coding accuracy		
Financial accuracy		

298. Complete and attach **Attachment 4 – Performance Guarantee Standards Provisions**. Proposer must be prepared to meet or exceed outlined performance standards. Performance below the standard level of performance will result in penalty as identified. Proposer should indicate the percentage of fees at risk in **Attachment 4**, in addition to any deviations from the current Performance Guarantee Standards.

299. Describe how a claims history is maintained for members who utilize both in and out-of-network services.

## Claims Policy

300. In one page or less, describe how Proposer reviews, edits and processes claims. Describe how Proposer's services are unique in the industry.

301. Explain all categories of "edits" Proposer has in place? (e.g., NCCI, Assistant Surgery, etc.)

302. Describe Proposer's claims editing software (third-party, proprietary). How was it developed? How is it used?

303. What percentage of claims submitted are denied for processing (pre-discount, pre-adjudication)? Please complete below table.

	Total of Claims Submitted	Number of Claims Denied	Total Billed Charges Submitted	Dollars of Billed Charges Denied
2013				
2014				

304. What percentages of services were denied for medical necessity in 2013, 2014 and YTD for 2015? Of those denials, what percentage was appealed and subsequently approved? Describe what types of services are most frequently denied and why these services are denied. Please complete below table.

	2013	2014	2015 (YTD)
% Denied			
% Appealed			
Subsequently Approved			

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305. Who is responsible for reviewing claim payment for correctness? Is this an internal or external process? Internal \_\_\_ External \_\_\_ Is there a charge for this? Yes \_\_\_ No \_\_\_ If yes, what is the cost? If an error is found, describe Proposer's process to credit the County?
306. Does Proposer agree to process and pay all legitimate claims as designated by the County and in accordance with Summary Plan Description? Yes \_\_\_ No \_\_\_

### Medical Management/Utilization Review

307. In two pages or less, please outline Proposer's core medical management program. Include examples of how Proposer has added significant value and how Proposer differentiates itself from Proposer's competitors.
- a) Please describe Proposer's Utilization Review and Case Management programs in detail. The County is interested in MCOs which have programs in place to monitor and manage both inpatient and outpatient utilization and which rely primarily on contract providers (rather than on the patient) for compliance with practice protocols. Please describe the following specific program(s) in place to monitor and evaluate delivery of care, identifying whether such programs are patient-initiated:
1. Pre-admission
  2. Concurrent Review
  3. Retrospective Review
  4. Ambulatory care
  5. Mental health Review
  6. Catastrophic case management
  7. Disease Management
  8. Wellness Initiatives
- b) List any combination of other coverages/services, which are required for use of Proposer's utilization review services.
- c) Describe how the claims payment system is integrated with the UR system, case management and disease management programs.
- d) Define the procedures and criteria (e.g., ISDA, AEP, CPHA/PAS) used for each of the various utilization review services (i.e., pre-admission review, continued stay, discharge planning, other services).
- e) Provide a summary of staff experience and expertise.
- f) From where will Proposer's services be provided? Will Proposer provide a toll free telephone number for employee and provider use? What are the hours and days worked by the certification staff?
- g) What is the turnaround time for certification services?
- h) Will Proposer allow an on-site audit of procedures and claims by the County or by a third party as contracted by the County? Explain any limitations.

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- i) Attach sample reports which indicate savings generated by the application of the utilization review process, as well as sample reports of the information, which will be submitted to the administrator for each claim. Identify how "savings" are determined.

308. With respect to Proposer's overall member contact rates:

- (a) In a 12- month period, what percentage of members is "contacted" by the medical management program? For this question, "contact" is a LIVE attempt to contact a member by a medical management professional either through a phone call to the member or to the member's spouse or the member's physician. If Proposer has other means of contacting members such as automated calls, mailings, text messaging or email blasts. Please exclude these from Proposer's contact statistics.
- (b) Of the members in (a), what percentage initially agreed to discuss their situation with the medical management professional? This is the "participation rate".
- (c) Of the members in (b), what percentage remained involved with the medical management professional to the end? (For example, if a member agrees to work with a case manager or a health coach, do they stay engaged until the case manager or health coach closes the case?)

309. In one page or less, outline Proposer's precertification program. Explain the nature of the program (i.e., notification, notification and steerage, denials) and why Proposer chose this particular approach.

- a. How many specific services does Proposer include for precertification?
  - i. Number
  - ii. Dollars
- b. Of the services identified in the above (Question 306 a) what percentage of those services were altered (steered, denied, delayed until another test was done, etc.)
  - i. Number
  - ii. Dollars

310. In one page or less, outline Proposer's Concurrent Review and Discharge Planning (Rounding) program.

- a. Of all hospital confinements, what percentage is subject to Rounding?
  - i. Number
  - ii. Dollars
- b. Of the hospital confinements identified in a., what percentage of those confinements were altered (transferred, discharged early, kept longer)
  - i. Number
  - ii. Dollars

311. Is Proposer's Utilization Management (UM) service located in Proposer's claims office? Yes \_\_\_ No \_\_\_ If no, where is it located?

312. What is the size of the UM staff in the claims office that Proposer is proposing to the County?

313. Does Proposer have a physician on staff to intervene on "problem" admissions or certifications? Yes \_\_\_ No \_\_\_

314. Describe the employee's responsibility for compliance with UM programs, in-network, out-of-network, and out-of-area.

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315. Are Proposer's utilization review service/requirements different in any way for in-network, out-of-network, or out-of-area participants?
316. Provide a list of services that require pre-authorization or pre-notification.
317. Do providers have access to Proposer's coverage positions or clinical guidelines? Please explain how.
318. Are network providers at risk for not following Proposer's Medical Management Program? Yes \_\_\_ No \_\_\_ Please explain.
319. Describe how inpatient utilization is managed. Specially address after hours, emergency, and in and out-of-network.
320. Is inpatient hospital census reviewed on a daily basis? Yes \_\_\_ No \_\_\_ If no, how often?
320. How does Proposer communicate with patients and family members regarding length of stay and discharge planning?
321. In two pages or less, describe Proposer's Case Management Program.
322. Provide a copy of the appeals/denial case management process. Provide documentation to demonstrate when/how these protocols are shared with providers and members.
323. How many Case Managers does Proposer have per 10,000 members? How many active cases per case manager? Average length of case?
324. Are there any cases the Case Management Program will not manage? Yes \_\_\_ No \_\_\_ If yes, describe.
325. Do members in Case Management have a consistent Nurse Manager presiding over each case? Yes \_\_\_ No \_\_\_
326. Describe how clinical progress is communicated to patients and physicians?
327. Describe how providers and members are made aware of Case Management.
328. Does Proposer report its Case Management results? Yes \_\_\_ No \_\_\_ If yes, include samples of such reporting.
329. What are the readmission rates (within 30 days of discharge) for South Florida (Miami-Dade, Broward, Palm Beach Counties)? Nationally?
330. Will specific clinical staff (such as MDs, RNs, LPNs, other) members be assigned/dedicated to the County account? Yes \_\_\_ No \_\_\_
331. Will the Medical Management Programs Proposer is proposing for the County provide the same services for HMO, POS, and Select plan designs options? Yes \_\_\_ No \_\_\_ If no, describe differences.
332. Describe Proposer's medical protocols to determine:
- a. Medical necessity
  - b. Medical appropriateness
  - c. Experimental and investigational treatment
333. Describe the type of reporting Proposer uses to track, analyze and assess cost savings:

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	REPORTS	FREQUENCY
		Monthly Quarterly or Annually
Enrollment		
Participation		
Utilization (Gyms)		
Health Risk Change (Pre & Post)		
Clinical Outcomes		
Participant Satisfaction		
Claims Savings	<input type="checkbox"/> Medical <input type="checkbox"/> RX <input type="checkbox"/> Diagnosis	
Short-Term Disability		
Absenteeism		
Productivity		
Quality of Life		
ROI		
Administration		
Wellness Savings		
Wellness Impact		

## Quality Assurance

334. In two pages or less, describe Proposer's Quality Assurance program.
335. Provide specific examples as to how Proposer's objective measurement and information sharing process has improved clinical and financial outcomes in South Florida (Miami-Dade, Broward and Palm Beach Counties) over the past two years.
336. Describe Proposer's process for sharing information with providers, facilities and hospitals.
336. What clinical studies were conducted in the past two years?
337. What interventions were put into place to improve outcomes as a result of the clinical studies?
338. Have any providers, facilities and hospitals in South Florida been sanctioned or terminated for quality reasons?  
Yes \_\_\_ No \_\_\_ If yes, please describe in detail.

## Member/Client Service

339. Please identify if any customer service functions are performed by a subcontractor and not the Proposer. Explain the use of such subcontractors.
340. Provide a copy of Proposer's most recent member satisfaction survey results and indicate the following:
- What percentage of survey participants were very satisfied or extremely satisfied with Proposer's plan?
  - Which aspect of Proposer's plan's performance received the lowest average satisfaction score?
  - What method does Proposer use to evaluate/measure satisfaction?

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- 341. What is the time commitment for a member service representative to call back a member on an issue?
- 342. What is the procedure when a member service call is received outside of Proposer's working hours? What is the time commitment for a member service representative to call back a member on an issue (e.g., within 24 hours, etc.)?
- 343. Do Proposer's member service representatives have multi-lingual capabilities? Yes \_\_\_ No \_\_\_ If yes, what are Proposer's non-English capabilities?
- 344. How will Proposer interface with the current administrator to assure a smooth implementation?
- 345. How does Proposer handle retroactive enrollment and cancellations? What are Proposer's time limitations relative to processing retroactive eligibility adjustments?
- 346. Does Proposer have the capability to enter corrections to eligibility records in real time?
- 347. Do corrections show up at providers (including pharmacies) in real time? If not, what is the delay?
  - a) None
  - b) 24 Hours
  - c) 48 Hours
  - d) 72 Hours
- 348. If desired by the County, can Proposer facilitate accepting and transferring historical data from the current administrator? Yes \_\_\_ No \_\_\_ If yes, please indicate if there is a cost for this service.
- 349. Describe how Proposer identifies, investigates and resolves possible fraudulent claims and how Proposer will notify the County.
- 350. How does Proposer track verbal and written complaints received by Proposer? Is there a difference between Medical, PBM, Wellness and/or Disease Management complaints?
- 351. Is Proposer able to report the number and types of complaints (both written and telephonic) received in a calendar year for all plan members (total population) and the County's members specifically? Yes \_\_\_ No \_\_\_
- 352. How many verbal and written complaints were received by Proposer (including any services that are subcontracted) per 1,000 members during 2012, 2013, and 2014?

**Medical/Pharmacy**

Year	Number per 1000
2012	
2013	
2014	

**Wellness/Disease Management**

Year	Number per 1000
2012	
2013	

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2014	
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353. Are the member grievances/appeals tracked and reported? Yes \_\_\_ No \_\_\_ If yes, is Proposer able to provide the County with a report capturing the number and types of grievances/appeals which are received from County members? Yes \_\_\_ No \_\_\_

354. Describe Proposer's formal grievance procedure, including timeframes, using the following categories:

- Member Notification of Right to File
- Filing of Formal Grievance
- Investigation of Grievance
- Use of Independent Reviewer

355. Can Proposer's plan track and report on customer service activity? Yes \_\_\_ No \_\_\_

356. Does Proposer's plan have a 24-hour toll free number for medical and pharmacy member services and provider services? Yes \_\_\_ No \_\_\_ If no, what are the days and hours of operation?

357. Describe the services and features members (Medical, PBM, and Wellness/Disease Management) have access to on Proposer's website or mobile application? Does Proposer provide any remote access tools for face to face interaction with doctors/nurses, (e.g., facebook, VideoMD, coaching, etc.).

- How are providers instructed to handle members who have not yet been issued member ID cards?
- Can Proposer accommodate information from carve-out vendors for ID cards? Describe any requirements and limitations.
- How many ID cards will be distributed per family?
- Is there a charge for replacement cards? Yes \_\_\_ No \_\_\_ If yes, what is the charge?
- What is Proposer's normal turnaround time for production and mailing of ID cards?
- Describe Proposer's 24-hour nurse line. Does Proposer report on usage? Yes \_\_\_ No \_\_\_
- What are Proposer's target goals for the following metrics: 1) Call response time, (% of calls answered within \_\_, abandonment rate, etc.) 2) Appointment Waiting time? Please complete the following table below.

Member Service	Target Goal	2014 Actual Performance
Average Speed of Answer		
Average Length of Call		
First Call Resolution Rate		
Call Abandonment Rate		

358. Describe Proposer's online resources that are available specifically in South Florida (Miami-Dade, Broward, and Palm Beach Counties) to the County's members:

Member Online Resources	Yes	No	Planned *
Provider Directory			
Links to Physicians' Websites			
Claim Status			

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Claims History			
Explanation of Benefits			
Provider Performance Information (Hospital Comparison/Profiles)			
Health Risk Assessment			
Personalized Health Record			
Plan Policies or SPDs			
Receive Personalized Health News/Information			
Health Coaching			
Ask a Nurse/Medical Questions			
Disease Specific Chat Rooms			
File Complaints			
E-mail Member Service			
Order Replacement ID Cards			
Other			

\*Must indicate date of anticipated implementation.

## Provider Fraud and Abuse

359. In one page or less, describe Proposer's provider fraud and abuse unit.
360. Describe how Proposer determines if services are "excessive", "abusive", or "of questionable need"? Please provide examples of each.
361. What percentage of claims submitted are determined to be "excessive", "abusive", or "of questionable need" from a provider perspective?  
 - number  
 - dollars
362. Of all the claims identified in the prior question, what percentage of total providers in the network were involved?
363. How many providers are investigated each year for fraud and abuse? How many of these providers have been removed from the network? How many dollars have been recovered from these providers?
364. How many providers are engaged when potential fraud and abuse is identified?
365. Of all the claims identified in the prior question, what percentage of total providers in the network were involved?

## Patient Fraud and Abuse

366. In one page or less, describe Proposer's patient fraud and abuse unit.

**PROPOSER INFORMATION**

367. Describe how Proposer determines if services are "excessive", "abusive", or "of questionable need"? Please provide examples of each.
368. What percentage of claims submitted are determined to be "excessive", "abusive", or "of questionable need" from a provider perspective?  
 - number  
 - dollars
369. Explain how Proposer integrates patient abuse with provider abuse.

**Data Services**

370. Provide a listing of Proposer's standard reports that will be provided to the County, and at what intervals these reports will be available, broken down by Medical Reporting, Pharmacy Reporting, Wellness Reporting and Disease Management Reporting. Does Proposer have the ability to provide state of the art management reporting capability, (e.g., Healthcare Effectiveness Data and Information Set (HEDIS) or similar reporting package)?
371. Ad hoc reports shall be available upon request (Medical, PBM, Wellness and Disease Management). Will there be an additional charge for these reports? Yes \_\_\_ No \_\_\_ If yes, what is the cost?
372. Confirm Proposer's ability and willingness to coordinate activities and share necessary eligibility and claims data with third party vendors (e.g. carve out vendors, consultants, etc.).
373. Describe points of integration between implementation and ongoing support teams.

**Pharmacy Benefits Manager Claims Processing**

The following questions are specific to the Proposer's internal or subcontracted PBM that is being proposed to the County as part of this Solicitation.

374. Describe how Proposer issues certificates of creditable coverage for Part D-eligible plan participants (both actives and retirees).
375. Identify if Proposer has any cost associated with Medicare Part D services.
376. Does the Proposer own its pharmacy electronic claims adjudication system or does the Proposer contract with an outside vendor? Yes \_\_\_ No \_\_\_ If yes, identify organization?
377. What is the Proposer's turnaround time for paying pharmacy manual claims?
378. Can the Proposer accommodate assignment of pharmacy benefits in the manual claims process? Yes \_\_\_ No \_\_\_
379. Describe the Proposer's disaster recovery plans for Internet, retail network and mail order, and specialty pharmacy processing systems. List the number of times and duration the Proposer's retail and mail order network processing system has experienced unscheduled down time over the past twelve months.
380. What are the Proposer's system capabilities for pharmacy out-of-area providers, deductibles, caps, and copayments?
381. Does the Proposer provide new drug alerts to the County as they are released to the market (including generics)? Yes \_\_\_ No \_\_\_ Does the Proposer communicate what the potential impact of the newly FDA approved drug will have on the County's plans? Yes \_\_\_ No \_\_\_

## PROPOSER INFORMATION

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382. Explain the Proposer's disaster plan for the Proposer's mail operation. Explain what will happen if the Proposer's mail facility cannot process prescriptions.
383. What is the guaranteed turnaround time for "clean" mail order/services prescriptions? Explain how the turnaround time is calculated (e.g., date stamp on receipt or when it arrives in pharmacy)? Please be specific.
384. What is the average turnaround time for "non-clean" mail order/services prescriptions? (those prescriptions that require an additional interaction)
385. How many prescriptions go through the Proposer's mail system each year? Please provide prescription accuracy percentages for the Proposer's mail service program (please provide for the past 2 years complete calendar years (2013 and 2014) and YTD 2015). What strategies does the Proposer utilize to improve its accuracy going forward?
386. Please describe the Proposer's hours of operation and locations for the Pharmacy Helpdesk? Do physicians have a separate dedicated access line? Yes \_\_\_ No \_\_\_
387. Provide information on the frequency and content of performance review meetings the Proposer would conduct for the County in the first and subsequent years of this contract.
388. Does the Proposer offer on-line eligibility maintenance for the County?
- If so, is there a charge?
  - Is there a charge for hard copy maintenance?
  - Explain how it works?
  - How often can changes be made?
389. How does the Proposer ensure that terminated members are removed from coverage? Will the County be held accountable for any charges if a terminated member receives benefits? Yes \_\_\_ No \_\_\_
390. Are employees and dependents listed separately? Yes \_\_\_ No \_\_\_ Can their pharmacy utilization be reported separately? Yes \_\_\_ No \_\_\_ How does the Proposer manage multiple dependents with the same birthday? (Twins, Triplets, etc.)
391. Since eligibility is determined online at point of sale, does the Proposer have a 1-800 number the member can call if there is problem? Are dependents listed by name on the pharmacy card? Or is only the employee listed on the card?
392. How often is membership updated? Can the membership be updated online by the County? Can this be done daily?
393. Are there any charges for membership cards? How many are included initially?
394. Can the Proposer do a combination medical/pharmacy card? Is there any additional charge for this?
395. Can the Proposer brand the medical/pharmacy card with the County's logo and name? Yes \_\_\_ No \_\_\_ If yes, is there any additional charge for this?
396. What is the charge for replacement cards?
397. What is the maximum number of Pharmacy cards allowed per family without any additional card production charges?
398. Can integrated ID cards be developed with a Medicare part D plan?
399. Can the Proposer report PBM savings each month with the billing statement? Yes \_\_\_ No \_\_\_
400. What is the Proposer's reporting capabilities? Please attach a portfolio of all available reports. Each should have a short description.
401. What level of analysis and advice is included in the Proposer's standard reporting package?

## PROPOSER INFORMATION

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402. Describe the Proposer's ad-hoc reporting capabilities, including programming charges. Which reports are provided as standard? How often are they generated?
403. Provide a specific list and a sample package of the Proposer's standard reports that will be included at no additional charge. Please note the frequency such reports will be provided.
404. What is the Proposer's fee for non-standard report production? Is this fee generated on a fixed cost per report or billed on an hourly basis? Give examples of non-standard reports.
405. How long does it take to receive requested non-standard reports from the Proposer? What is the process to request a non-standard report?
406. Are reports available online? Yes \_\_\_ No \_\_\_ How many people can get access? Can the County request their consultant have online accessibility? Is there a charge for online accessibility? Any special computer specifications needed to get online reports?
407. How often are reports provided and can they be reported by division, location, department or union subdivision within a single employer group at no additional charge?
408. Are paper and electronic claims all included in the reports? Yes \_\_\_ No \_\_\_
409. Does the County have the ability to access the Proposer's database in real time for purposes of adds/deletes, tracking plan experience, utilization patterns, and other available plan information? Yes \_\_\_ No \_\_\_
410. Describe how Proposer can provide reports to the County. (e.g., CD, paper) Is there any additional charge for this? How often are reports generated?
411. Provide a sample of the rebate reports that will be provided to the County.
412. How is data benchmarked for the County? Are geographic and demographic benchmarks identified?
413. Is the Proposer's reporting system capable of reporting single/couple/family membership participation on a month-to-month basis? Yes \_\_\_ No \_\_\_ Can reports be broken down by bargaining unit? Yes \_\_\_ No \_\_\_
414. Does the Proposer track and monitor prescription utilization outliers?
- Physicians
  - Pharmacists
415. Does the Proposer report clinical savings each month? Yes \_\_\_ No \_\_\_ Can the Proposer guarantee savings? Yes \_\_\_ No \_\_\_ If yes, what are the savings?
416. Does the Proposer conduct pharmacy audits? Yes \_\_\_ No \_\_\_ If yes, what percent of claims and/or pharmacies are audited on an annual basis? What is the average amount recovered in an audit?
417. Does the Proposer hire external auditors? Yes \_\_\_ No \_\_\_ How do they charge for the service?
418. How does the Proposer handle the distribution of the money recovered as a result of pharmacy audits?

### Implementation

419. Describe Proposer's implementation process if Proposer is the selected Proposer, including significant deliverables, project manager and timelines for an implementation date of January 1, 2016. Assuming the County provides notification of award in September, 2015.
420. What is the shortest lead time the Proposer can implement a group the size of the County?

**PROPOSER INFORMATION**

421. Describe Proposer's standard banking arrangement for self-funding. Include:

- How and when the account is funded.
- Options Proposer has available for reimbursement frequency and method.
- The minimum funding balance requirement and its development, and any initial deposit requirements.

422. Provide a description (including any report samples) of the services Proposer can provide the County to fund, monitor and reconcile the self-funding account included in Proposer's proposed pricing. Please describe any additional services available separately and provide cost of each service.

423. Describe how Proposer develops its administrative pricing for self-funded accounts.

- What do administrative costs (including network charges) represent?
- As a percent of claims?
- As a capitated dollar amount per employee?

424. Does Proposer subrogate claims? Yes \_\_\_ No \_\_\_ If yes, please explain how. Is there a charge for this? Yes \_\_\_ No \_\_\_ Identify all charges associated with subrogation including types of claims, COB, third party vendors, etc.

425. Is there a subrogation report Proposer provides to the County based on the outcomes of this process? Yes \_\_\_ No \_\_\_ If so, what type of information is included in the reporting?

426. Provide samples of the following communication materials in Proposer's submittal. Provider directories (note if available on the Web)

- ID cards
- Sample EOBs
- Sample wellness/health promotion newsletter and program description
- Web site address
- Sample enrollment kits

427. Is Proposer willing to customize the above materials during implementation and on an on-going basis, as may be needed throughout the year and annually, thereafter? Yes \_\_\_ No \_\_\_ Is there an additional charge for customization? Yes \_\_\_ No \_\_\_ If yes, provide the additional charges.

**Price/Financial Responses**

428. Proposer must complete Form B-1, Self-Funded Employee Group Healthcare Program, Price Proposal/Financial Schedule, attached herein.

**PROPOSER INFORMATION**

429. Proposer must list all proposal qualifications and/or caveats associated with Proposer's proposed Program being offered.
430. What is the cost impact as a percentage of claims for gatekeeper versus non-gatekeeper models?
431. What is Proposer's overall network pricing as compared to prevailing Medicare reimbursement for hospitals? For physicians?
432. Do any network contracts include outlier provisions? Yes\_\_\_ No\_\_\_ If yes, explain.
433. What database does Proposer utilize to determine reasonable and customary (R&C)? What percentile does Proposer use to pay medical claims? How often is the database updated? Does Proposer use different R&C levels for different products?
434. Provide hospital cost data broken down by county for **Miami-Dade County, Broward County and Palm Beach County.**

**Miami-Dade County Only**

	2013			2014			2015		
	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select
Average cost per admission									
Average cost per day									
Average discount level									
Average length of stay									
Days per 1000									
Admissions per 1000									

**Broward County Only**

	2013			2014			2015		
	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select
Average cost per admission									
Average cost per day									
Average discount level									
Average length of stay									
Days per 1000									
Admissions per 1000									

**Palm Beach County Only**

	2013			2014			2015		
	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select
Average cost per admission									
Average cost per day									
Average discount level									
Average length of stay									
Days per 1000									

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Admissions per 1000									
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435. Indicate Proposer's current **2015 network payment** method employed for each type of service/product and network proposed.

Provider Type/Service	Capitation	DRG/Case Rates	Per Diem	% of Charges	Fee Schedule	Average Cost Per Day or Per Service
Adult Primary Care						
Ambulatory Surgery Centers						
Chiropractic						
Complex Imaging						
Dermatology						
Durable Medical Equipment						
Emergency Room						
Gynecology						
Hospital Based Providers Anesthesia Radiology Pathology Emergency						
Hospital Inpatient Medical/Surgical Intensive Care Neonatal Maternity						
Hospital Outpatient Surgical Non-Surgical						
Hospice						
Obstetrics						
Outpatient Laboratory						
Other Specialists						
Pediatric						
Podiatry						
Rehabilitation Facility						
Skilled Nursing Facility						
Transplant Services						
Urgent Care Center						

436. Complete the following tables for hospital inpatient and hospital outpatient services based on 2014 data. Identify hospital Pricing Analysis for **Miami-Dade County and Broward County Only**.

**Miami- Dade County Only**  
**Hospital Inpatient**

Type of Admission	Sub-Category	% of Admissions		% of Days		Average Eligible Charge Per Day		Average Negotiated Per Diem
		HMO	PPO	HMO	PPO	HMO	PPO	
		%	%	%	%	\$	\$	\$
Medical/Surgical								

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ICU/CCU	Adult	%	%	%	%	\$	\$	\$
	Pediatric							
	Neonatal	%	%	%	%	\$	\$	\$
Maternity	Vaginal	%	%	%	%	\$	\$	\$
	C-Section	%	%	%	%	\$	\$	\$
Cardiac Surgery		%	%	%	%	\$	\$	\$
<b>Total</b>								

Note: Eligible charges are submitted charges less ineligible charges such as duplicates, non-covered items, etc. Average Negotiated Per Diem should include the impact of any outlier provisions.

**Hospital Outpatient**

Type of Service	Reimbursement Method		Average Eligible Charge Per Encounter		Average Allowed Amount Per Encounter		Net Effective Discount %	
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO
Surgery			\$	\$	\$	\$	%	%
Emergency Room			\$	\$	\$	\$	%	%
Radiology			\$	\$	\$	\$	%	%
Pathology			\$	\$	\$	\$	%	%
Therapy (PT/OT/ST)			\$	\$	\$	\$	%	%
Other			\$	\$	\$	\$	%	%
<b>Total</b>								

Note: Reimbursement Method refers to case rates, flat fees, % of Medicare, Allowable, % Discount, etc.

**Broward County Only**

**Hospital Inpatient**

Type of Admission	Sub-Category	% of Admissions		% of Days		Average Eligible Charge Per Day		Average Negotiated Per Diem
		HMO	PPO	HMO	PPO	HMO	PPO	
Medical/Surgical		%	%	%	%	\$	\$	\$
ICU/CCU	Adult	%	%	%	%	\$	\$	\$
	Pediatric							
	Neonatal	%	%	%	%	\$	\$	\$
Maternity	Vaginal	%	%	%	%	\$	\$	\$
	C-Section	%	%	%	%	\$	\$	\$
Cardiac Surgery		%	%	%	%	\$	\$	\$
<b>Total</b>								

Note: Eligible charges are submitted charges less ineligible charges such as duplicates, non-covered items, etc. Average Negotiated Per Diem should include the impact of any outlier provisions.

**Hospital Outpatient**

Type of Service	Reimbursement Method		Average Eligible Charge Per Encounter		Average Allowed Amount Per Encounter		Net Effective Discount %	
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO
Surgery			\$	\$	\$	\$	%	%
Emergency Room			\$	\$	\$	\$	%	%

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Radiology			\$	\$	\$	\$	%	%
Pathology			\$	\$	\$	\$	%	%
Therapy (PT/OT/ST)			\$	\$	\$	\$	%	%
Other			\$	\$	\$	\$	%	%
<b>Total</b>								

Note: Reimbursement Method refers to case rates, flat fees, % of Medicare, Allowable, % Discount, etc.

437. Provide Proposer's 2014 per member/per month claim (PMPM) claim cost for Miami-Dade and Broward County for each type of plan offered.

**Miami-Dade County**

	PMPM – HMO	PMPM – POS	PMPM – Select
Diagnostic			
Hospital Inpatient			
Hospital Outpatient			
Prescription			
Primary Care (PCP)			
Specialist			
Emergency Room			
Urgent Care			

**Broward County**

	PMPM – HMO	PMPM – POS	PMPM – Select
Diagnostic			
Hospital Inpatient			
Hospital Outpatient			
Prescription			
Primary Care (PCP)			
Specialist			
Emergency Room			
Urgent Care			

438. Provide the contracted fees by type of provider and number of providers in each category for Proposer's South Florida (Miami-Dade, Broward, and Palm Beach Counties) network Proposer is proposing:

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**PROPOSER INFORMATION**

Specialty	# of Contracted Providers	Contracted Fee
<b>Psychiatrist</b>		
Adult		
Child		
<b>Psychologist</b>		
Adult		
Child		
<b>Licensed Clinical Social Worker</b>		
<b>Other Health Providers (Specify)</b>		
<b>ESS Providers (Specify)</b>		

439. Specify Proposer's experience for Proposer's population in 2012, 2013 and 2014 by plan type for Medical (non-BH/SA) inpatient services:

2012	Days/1000 members			Average Length of Stay In-Network (ALOS)			Cost per day In-Network			ALOS TOTAL			Cost per day TOTAL		
	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select
Medical/Surgical															
Maternity															
Neonatal															
Intensive Care															
CCU/PCU															
<b>Total</b>															

2013	Days/1000 members			ALOS In-Network			Cost per day In-Network			ALOS TOTAL			Cost per day TOTAL		
	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select
Medical/Surgical															
Maternity															
Neonatal															
Intensive Care															
CCU/PCU															
<b>Total</b>															

2014	Days/1000 members			ALOS In-Network			Cost per day In-Network			ALOS TOTAL			Cost per day TOTAL		
	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select	HMO	POS	Select
Medical/Surgical															
Maternity															
Neonatal															
Intensive Care															
CCU/PCU															
<b>Total</b>															

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440. Provide the total number of encounters, for South Florida (Miami-Dade, Broward, and Palm Beach Counties), for Behavioral Health and Substance Abuse services in 2012, 2013, and 2014. Complete tables below.

<b>Inpatient-Hospital Days/1,000 Members</b>						
	<b>2012 Days/1,000</b>	<b>2012 Average Cost Per Day</b>	<b>2013 Days/1,000</b>	<b>2013 Average Cost Per Day</b>	<b>2014 Days/1,000</b>	<b>2014 Average Cost Per Day</b>
Psychiatric						
Alcohol/Sub- stance abuse						
<b>Total</b>						

<b>Outpatient-Visits/1,000 Members</b>						
	<b>2012 Visits/1,000</b>	<b>2012 Average Cost Per Visit</b>	<b>2013 Visits/1,000</b>	<b>2013 Average Cost Per Visit</b>	<b>2014 Visits/1,000</b>	<b>2014 Average Cost Per Visit</b>
Psychiatric						
PHD						
MD						
MS						
RN						
Alcohol/Sub- stance abuse						
PHD						
MD						
MS						
RN						
<b>Total</b>						

**Pharmacy Benefit Manager**

The following questions are specific to the Proposer's internal or subcontracted pharmacy benefit manager that is proposed to the County, as part of this Solicitation.

- 441. Provide a listing of standard programs and services that are included in the Proposer's base pricing arrangement.
- 442. If there is a fee for paper claim filing, what is the fee per claim for paper claim filing? Describe the paper claim process.
- 443. Provide a listing of standard programs and services
- 444. Does the Proposer provide guaranteed discounts for retail brand and generic medications? Yes \_\_\_ No \_\_\_ If yes, please provide the guaranteed discounts for retail brand and generic.
- 445. Does the Proposer provide guaranteed discounts for mail brand and generic medications? Yes \_\_\_ No \_\_\_ If yes, please provide the guaranteed discounts for mail brand and generic.
- 446. Does the Proposer charge an administrative fee? Yes \_\_\_ No \_\_\_ if yes, what is the charge?
- 447. Is the Proposer pricing transparent or traditional or a hybrid? Please describe and differentiate.
- 448. Provide a listing of additional services and their applicable costs.

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449. Please provide book of business pricing per unit and per day (and other specified information) for the past 6 months as of January 2015 for the top drugs on Excel file – (file provided-just fill in ingredient cost information- exclude rebates, dispensing fees, admin fees, co-pay's, and taxes.

450. Maximum Allowable Cost (MAC) program, please be specific for the following items:

- How is MAC pricing established?
- Are various MAC pricing levels available or does the Proposer have only one set of MAC pricing? If more than one, explain why.
- Of the total generics available on the market what percentage of those are on the Proposer's MAC list.
- How many drugs are on the Proposer's MAC list? Define by number of GPI's and NDC's.
- How is it updated? How frequently?
- Provide full MAC list by GPN or GPI by completing and attaching **Exhibit 4 – MAC List Sample**.

451. What is the Proposer's MAC program baseline discount? Does the Proposer guarantee such discount? Yes \_\_\_  
No \_\_\_

452. How often does the Proposer MAC pricing baseline change? Be Specific.

453. Does the Proposer use a maximum reimbursement amount and is it different than a MAC? Explain how.

454. If claim is rejected, is there any additional administrative charge, and if so who is charged?

455. Does the Proposer utilize a Usual and Customary (U&C) clause in the Proposer's contracts with network pharmacies?  
Yes \_\_\_ No \_\_\_ If yes do the claims still adjudicate through the system? Is the payer charged a dispensing fee?

456. Does the Proposer have a U&C in the mail service? Yes \_\_\_ No \_\_\_ Is there a U&C with a 90 day at retail program?  
Yes \_\_\_ No \_\_\_

457. If a discount from the Average Wholesale Price (AWP) is used in determining the reimbursement level, from what source is the AWP determined? Is the same AWP source used for all claims (i.e., retail vs. mail; generic vs. brand; brand vs. brand alternative)? Yes \_\_\_ No \_\_\_ If no, explain exceptions.

458. Which pricing guide does the Proposer use for brand AWP? How often does the Proposer update pricing in the Proposer's system?

459. Does the **Brand** AWP discount quoted include U&C claims or zero-balance claims or DUR savings? Yes \_\_\_ No \_\_\_

460. Does the **Generic** AWP discount quoted include U&C claims or zero-balance claims or DUR savings? Yes \_\_\_  
No \_\_\_

461. Does the contract pricing negotiated with pharmacies allow the Proposer's organization to keep the differential between the contracted amount and the amount billed to the County (spread pricing)? Yes \_\_\_ No \_\_\_

- If the Proposer's organization keeps the differential, please identify the pricing the Proposer's organization negotiates with the pharmacies in each of the respective networks under review.

462. Does the Proposer employ any negative spread in the Proposer's retail brand discounts? Yes \_\_\_ No \_\_\_

463. Does the Proposer employ any negative spread in the Proposer's retail dispensing fees? Yes \_\_\_ No \_\_\_

464. Does the Proposer's mail service re-package any medications and then use a different NDC to increase reimbursement? Yes \_\_\_ No \_\_\_

465. How long is the Proposer's financial quote guaranteed for?

466. What additional charges (i.e., clinical programs, ad hoc reports, etc.) are included in the Proposer's quote if not covered under another question?

**PROPOSER INFORMATION**

467. Are all switching charges paid by the pharmacies? Yes \_\_\_ No \_\_\_ Are there any exceptions?

468. With which transaction ("switch") company does the Proposer's network contract?

- ENVOI
- NDC
- GCC
- Argus
- Or can the Proposer's company also function as a "switch"

469. Does the Proposer sell, distribute or provide any claims data and the County's information to outside vendors? Yes \_\_\_ No \_\_\_ If yes, describe.

1. Identify for the County if there are any areas of service that are not included in the Scope of Services (see Section 2.0), which Proposer would recommend be considered for addition. Elaborate on Proposer's recommendation and describe how the Proposer would assist with service provision.

**PROPOSER INFORMATION**

2. Describe Proposer's approach to developing an alternative plan design (utilizing different networks, formularies, etc.) that may yield significant cost savings to the County (refer to Section 2.11 of the Scope of Services).
3. Describe Proposer's Alternative Plan design, including plan summary and details for each benefit level.
4. Describe the provider network the Proposer is offering, including how it compares to the County's current network.
5. Explains Proposer's formulary for the Alternative Plan design and how it compares to the County current formulary.
6. Explain Proposer's actuarial assumptions and criteria used to meet Proposer's stated savings target (i.e., enrollment, etc.) and describe the alternative plans' exclusions and limitations.



AFFIDAVIT OF MIAMI-DADE COUNTY
LOBBYIST REGISTRATION FOR ORAL PRESENTATION

(1) Solicitation Title: Solicitation No.:
(2) Department:
(3) Proposer's Name:
Address: Zip:
Business Telephone: ( ) E-Mail:

(4) List All Members of the Presentation Team Who Will Be Participating in the Oral Presentation:

Table with 4 columns: Name, Title, Employed By, Email Address. Multiple empty rows for data entry.

(ATTACH ADDITIONAL SHEETS IF NECESSARY)

The individuals named above are Registered and the Registration Fee is not required for the Oral Presentation ONLY.

Any person who appears as a representative for an individual or firm for an oral presentation before a County certification, evaluation, selection, technical review or similar committee must be listed on an affidavit provided by the County. The affidavit shall be filed with the Clerk of the Board at the time the response is submitted. The individual or firm must submit a revised affidavit for additional team members added after submittal of the proposal with the Clerk of the Board prior to the oral presentation. Any person not listed on the affidavit or revised affidavit may not participate in the oral presentation, unless he or she is registered with the Clerk's office and has paid all applicable fees.

Other than for the oral presentation, Proposers who wish to address the county commission, county board or county committee concerning any actions, decisions or recommendations of County personnel regarding this solicitation in accordance with Section 2-11.1(s) of the Code of Miami-Dade County MUST register with the Clerk of the Board and pay all applicable fees.

I do solemnly swear that all the foregoing facts are true and correct and I have read or am familiar with the provisions of Section 2-11.1(s) of the Code of Miami-Dade County as amended.

Signature of Authorized Representative: Title:

STATE OF

COUNTY OF

The foregoing instrument was acknowledged before me this

by, a, who is personally known (Individual, Officer, Partner or Agent) (Sole Proprietor, Corporation or Partnership)

to me or who has produced as identification and who did/did not take an oath.

(Signature of person taking acknowledgement)

(Name of Acknowledger typed, printed or stamped)

(Title or Rank)

(Serial Number, if any)

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**Form B-1  
Self-Funded Employee Group Healthcare Program  
Price Proposal/Financial Schedule**

**A. PROPOSED PRICE/FINANCIAL SCHEUDLE**

The proposed Administrative Services Only Fees (ASO Fees) for providing all services stated in Section 2.0, Scope of Services (except for Sections 2.11 and 2.12), but including the Plan Designs Worksheet identified in Attachment 5, should be stipulated below in Section A. Prices requested below should be provided on a per Plan Year basis.

**B. ADDITIONAL PLAN DESIGN(S)**

This Section is for informational purposes only and will not be utilized for scoring purposes. The County reserves the right to negotiate and contract for the Additional Plan Design(s)/Services at the County's sole discretion with the selected Proposer.

ASO FEES	A. Core Services, Wellness and Disease Management Included			B. Additional Plan Design(s) to include Core Services, Wellness and Disease Management		
	PY 2016	PY 2017	PY 2018	PY 2016	PY 2017	PY 2018
Expected Paid Claims						
Expected Change in Claim Reserves (PEPM)						
ASO Fees, includes the following: (PEPM) <ul style="list-style-type: none"> <li>• Access Fees</li> <li>• Utilization Review/Medical Management Fees</li> <li>• Pharmacy Interface Fees</li> <li>• Quality Assurance</li> <li>• Claims Administration</li> <li>• Credentialing</li> <li>• Grievance/Appeals Administration and External Appeals</li> <li>• DUR Fees</li> <li>• Behavioral Health/Substance Abuse</li> <li>• Standard Reporting</li> </ul>						
Wellness Program Fees (PEPM/PPPM)						
Set-Up Fees						
Renewal Fees						
Base Fee						
Biometric Screenings (Per Screening)						
Health Risk Assessments (HRA's)						
Health Fairs						
Incentive Administration						
Other (State and Snow PEPM/Per Participant Per Month Cost)						
<b>Web/Phone Based Programs</b>						
Weight Loss – Nutrition						
Walking						
Stress Reduction						
Smoking Cessation						
Physical Activity						

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Health Coaching (one -- one)						
<b>On-Site Components Offered</b>						
Weight Loss – Nutrition						
Walking						
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Stress Reduction						
Smoking Cessation						
Physical Activity						
On-Site Coordinator						
Reporting						
Quarterly and Annual Participation and ROI						
Ad Hoc Reports						
<b>Disease Management Program Fees (PEPM/Per Participate Per Month)</b>						
Asthma						
CAD						
COPD						
Diabetes						
Depression						
Hypertension						
Other						
Set-Up Fees						
Renewal Fees						
Other (State and Show PEPM/Per Participant Per Month Cost)						
Base Fee						
Reporting						
Quarterly and Annual Participation and ROI						
Ad Hoc Reports						
<b>Lifestyle Management Programs (PPPA)</b>						
<b>Cobra Administrative Fees (PEPM)</b>						
<b>HIPAA Administrative Fees (PEPM)</b>						
<b>Claim Fiduciary Fees (PEPM)</b>						
<b>Onsite Customer Service</b>						
<b>Coordination of Benefits – Break down of all fees</b>						
<b>Subrogation Services – Break down of all fees</b>						
<b>Negotiated Bill Services – Break down of all fees</b>						
<b>Ad hoc Reporting</b>						

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Interface with Other Carve-out Vendors						
Run-Out Fees and Length						
Conversion Plan Fee						
Other Fees (PEPM) – Be Specific						
<b>TOTAL ADMINISTRATIVE FEES</b>						

**Notes:**

1. Fees in the initial Plan Year (2016) shall be quoted on a mature basis (i.e., fees are inclusive of run-out administration). Fees should be quoted for Plan Years 2016, 2017 and 2018. If the fee for one of the listed services is included in the fee for another service (e.g., if the COBRA fee is included in the ASO fee), then enter "included" in the cell for that fee.
2. The County prefers a guaranteed blended rate for a minimum of 36-months (initial 3 Plan Years) for the ASO fees and other fees, as outlined above.
3. Identify any other fees or costs that are not stated above which would be included in Proposer's proposed pricing. Include the amount of such fee(s)/cost(s), purpose of fee(s)/cost(s), and detail how the fee(s)/cost(s) will be billed to the County. Proposer should also include any capitated claim expenses.
4. Identify all fees, savings programs, percentages of savings, etc. and the period of time for which these fees will remain fixed.
5. Identify any impact to the above fees should the County carve out the Wellness and Disease Management Programs at a future date. Please explain the impact of the change.
6. Only the proposed fees in Section A will be used to determine the price points for the Price criterion, as indicated in Section 4.2, of this Solicitation. Section B will not be scored and is for informational purposes only.

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**RFP No. 00196**

**Self-Funded Employee Group Healthcare Program**

**Due to the large size of the following attachments and exhibits, the below link is available for access of such documents, in their entirety.**

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**Attachments & Exhibits**

**Attachments**

**Attachment 1 - Census**

**Attachment 2 - Summary of Benefits Coverage (SOBC) Handbook**

**Exhibits**

**Exhibit 2 - Medical Claims Re-pricing Analysis**

**Exhibit 3 - Pharmacy Claims Re-pricing Analysis**

**Exhibit 5 - Specialty Prescription Drug List Sample**

**Exhibit 6 - Top Utilized Physicians/Providers**

**RFP No. 00196**

**Self-Funded Employee Group Healthcare Program**

**Attachment 1 - Census**

Please go to the following link to access Attachment 1: \\miamidade\nas1\dpm\DPM-Share\BidSync-Share\RFP-00196

**RFP No. 00196**

**Self-Funded Employee Group Healthcare Program**

**Attachment 2 - Summary of Benefits Coverage (SOBC) Handbook**

Please go to the following link to access Attachment 2: <\\miamidade\nas1\dpm\DPM-Share\BidSync-Share\RFP-00196>

Attachment 3 - Health Plan Premium Equivalent Rates

Miami-Dade County  
2015 Health Plan Premium Rates - No Change in Benefits

Active Employees (Non-Redesign)

Plan	Tier	2015				Monthly COBRA Rates
		Monthly Rates				
		Total	County	Subsidy	Employee	
High HMO	EE	\$676.04	\$676.04	\$0.00	\$0.00	\$689.58
	ES	\$1,418.97	\$676.04	\$246.35	\$496.58	\$1,447.35
	EC	\$1,314.32	\$676.04	\$208.87	\$429.41	\$1,440.61
	EF	\$1,730.52	\$676.04	\$368.62	\$685.86	\$1,765.13
Low HMO	EE	\$635.46	\$635.46	\$0.00	\$0.00	\$648.17
	ES	\$1,334.52	\$635.46	\$230.92	\$468.14	\$1,361.71
	EC	\$1,236.02	\$635.46	\$195.80	\$404.76	\$1,260.70
	EF	\$1,627.71	\$635.46	\$345.50	\$646.75	\$1,660.29
POS	EE	\$1,307.06	\$1,267.83	\$3.73	\$35.50	\$1,333.20
	ES	\$2,488.40	\$1,267.83	\$399.43	\$821.14	\$2,588.17
	EC	\$2,280.48	\$1,267.83	\$331.35	\$681.30	\$2,326.09
	EF	\$3,377.66	\$1,267.83	\$690.34	\$1,419.49	\$3,445.21

2015 Health Plan Premium Rates - With Redesign

Active Employees (Re-Design)

Plan	Tier	2015				Monthly COBRA Rates
		Monthly Rates				
		Total	County	Subsidy	Employee	
High HMO	EE	\$653.81	\$491.31	\$0.00	\$162.50	\$666.89
	ES	\$1,372.28	\$491.31	\$429.54	\$451.43	\$1,399.78
	EC	\$1,271.08	\$491.31	\$389.39	\$390.38	\$1,296.50
	EF	\$1,673.58	\$491.31	\$558.76	\$623.51	\$1,707.05
POS	EE	\$1,264.08	\$1,047.41	\$0.00	\$216.67	\$1,289.36
	ES	\$2,406.54	\$1,047.41	\$612.63	\$746.50	\$2,454.67
	EC	\$2,205.45	\$1,047.41	\$538.68	\$619.36	\$2,249.56
	EF	\$3,266.55	\$1,047.41	\$928.70	\$1,290.44	\$3,331.88
Select HMO	EE	\$608.03	\$608.03	\$0.00	\$0.00	\$620.39
	ES	\$1,276.23	\$608.03	\$308.53	\$359.67	\$1,304.75
	EC	\$1,182.09	\$608.03	\$268.56	\$305.50	\$1,209.73
	EF	\$1,556.43	\$608.03	\$437.06	\$511.34	\$1,587.56

2015 Retiree Premiums for Health Plans - With Redesign

Pre Age 65 Medicare

Plan	Tier	2015 Rates		
		Total	County	Retiree
High HMO	EE	\$653.81	\$204.36	\$449.45
	ES	\$1,372.28	\$360.38	\$1,011.90
	EC	\$1,271.08	\$339.47	\$931.61
	EF	\$1,673.58	\$418.43	\$1,255.15
Low HMO	EE	Not Available		
	ES	Not Available		
	EC	Not Available		
	EF	Not Available		
POS	EE	\$1,264.08	\$177.80	\$1,086.28
	ES	\$2,406.54	\$302.75	\$2,103.79
	EC	\$2,205.45	\$175.12	\$2,030.33
	EF	\$3,266.55	\$711.37	\$2,555.18
Select	EE	\$608.03	\$204.36	\$403.67
	ES	\$1,276.23	\$360.38	\$915.85
	EC	\$1,182.09	\$339.47	\$842.62
	EF	\$1,556.43	\$418.43	\$1,138.00

Post Age 65 Medicare

Plan	Tier	2015 Rates		
		Total	County	Retiree
High	Retiree Only	\$795.40	\$233.58	\$561.82
	Ret + Spouse	\$1,362.67	\$260.15	\$1,102.52
Low	Retiree Only	\$710.31	\$208.59	\$501.72
	Ret + Spouse	\$1,216.93	\$232.33	\$984.60
High No Rx	Retiree Only	\$345.73	\$101.53	\$244.20
	Ret + Spouse	\$597.32	\$113.08	\$479.24

Miami-Dade County  
2015 for Dental and Vision

**Dental**

		Delta Standard	Delta Enhanced	MetLife Standard	MetLife Enhanced	Humana Standard	Humana Enhanced	County Contribution
Total	EE	\$0.00	\$6.83	\$0.00	\$2.10	\$0.00	\$4.45	\$8.00
Monthly	EE + 1	\$5.24	\$16.58	\$3.01	\$6.52	\$14.09	\$22.89	\$10.01
Premium	Family	\$12.22	\$31.03	\$7.06	\$13.10	\$31.53	\$45.72	\$31.22

Monthly	EE	\$31.84	\$41.69	\$10.21	\$14.86	\$8.16	\$15.12
COBRA	EE + 1	\$63.00	\$82.43	\$16.87	\$24.63	\$13.50	\$25.07
Premium	Family	\$101.54	\$132.91	\$25.82	\$39.16	\$20.62	\$39.80

**Vision**

		Meltife Vislon	County Contribution
Total	EE	\$4.14	\$0.00
Monthly	EE + 1	\$8.60	\$0.00
Premium	Family	\$15.23	\$0.00

Monthly	EE	\$4.22
COBRA	EE + 1	\$8.47
Premium	Family	\$15.54

**Attachment 4**  
**Performance Guarantee Standard Provisions**

**A. Medical (excludes Prescription Drugs)**

Category	Standard	Measurement	Percentage of Fees at Risk	Proposed Changes
<b>Claims Processing</b>				
Claims Financial Accuracy	99% payment accuracy ratio	Total dollars paid correctly (total dollars actually paid minus the absolute value of overpayments and underpayments) divided by total dollars that should have been paid for the audited sample. Prescription Drug claims are excluded from this measurement.	Maximum Annual Penalty: \$150,000	
Claim Coding Accuracy	95% coding accuracy ratio	Total number of claims correctly processed divided by the total number of claims audited. Prescription Drug claims are excluded from this measurement.	Maximum Annual Penalty: \$150,000	
Claims Turnaround	90% within 10 business days; 98% within 22 business days; Pended claims not to exceed 6% of processed claims	Time from the date a claim is received to the date it is processed (i.e., paid, pended or denied) excluding weekends and holidays (clean claims only). Prescription Drug claims are excluded from this measurement.	Maximum Annual Penalty: \$150,000	
<b>Customer Service</b>				
Telephone Response Time (with a live person)	100% within 30 seconds	Telephone system should provide statistics regarding time from call connecting to the 800# to the time it is answered by a live person.	Awardee and MDC will monitor response time to ensure optimal performance is met, and will meet as needed to address performance issues.  Maximum Annual Penalty: \$25,000	
Telephone Abandonment Rate	Less than 5%	Percentage of calls in which the caller hangs up before the call is answered by a live person.	Awardee and MDC will monitor response time to ensure optimal performance is met, and will meet as needed to address performance issues.  Maximum Annual Penalty: \$25,000	
ID Cards	98% mailed within 5 business days	Time from the date of receipt of each electronic eligibility file to the date the ID card is mailed excluding weekends and holidays.	With the exception of the annual open enrollment period, Awardee agrees to the standard requiring 98%	

**Attachment 4  
Performance Guarantee Standard Provisions**

Category	Standard	Measurement	Percentage of Fees at Risk	Proposed Changes
			<p>of ID cards being mailed within 5 business days of receipt of a valid eligibility file. During the peak open enrollment period, Awardee will commit to a standard of mailing 98% of ID cards within 10 business days.</p> <p>Maximum Annual Penalty: \$100,000</p>	
Annual Employee Satisfaction Survey	Achieving agreed-upon employee satisfaction results each year during contract period	Survey instrument to be developed by County and agreed upon with Contractor that facilitates separate reporting for members currently enrolled with Contractor vs. newly enrolled members beginning in 2016. Each category of membership will be separately evaluated and the maximum annual penalty will be divided equally between the two (2) categories.	<p>Contractor is expected to achieve satisfied or very satisfied survey results of 85% or higher for the members enrolled with Contractor prior to 2016. For new enrollees in 2016, Contractor is expected to achieve satisfaction results of 75% or higher.</p> <p>Maximum Annual Penalty: \$150,000</p>	
<b>Eligibility</b>				
Turnaround	Bi-weekly eligibility electronic files updated daily	Electronic acknowledgement of file receipt and confirmation of date update performed provided to the County within one (1) business day after the file is posted to the County server.	Maximum Annual Penalty: \$50,000	
Accuracy	98% of all eligibility records complete and accurate	Total number of records complete and accurate divided by the total number of records audited.	Maximum Annual Penalty: \$150,000	
<b>Reporting</b>				
Release of Reports	Provided within specified days of end of reporting period, based on report	Time from the date the reporting period closes to the date the report is mailed. Reporting period close is dependent on the frequency of the specific report.	Awardee will provide MDC with agreed-upon reports in electronic format within 15 business days after the end of the reporting period.	

**Attachment 4  
Performance Guarantee Standard Provisions**

Category	Standard	Measurement	Percentage of Fees at Risk	Proposed Changes
			Maximum Annual Penalty: \$0	
<b>Implementation</b>				
Miami-Dade County Satisfaction	Meet 95% of all targets agreed upon by the County and the Contractor	Implementation schedule will be mutually established with measurable targets and commitments	Maximum Annual Penalty: \$25,000	
<b>Annual Customer Satisfaction</b>				
Miami-Dade County Satisfaction	Satisfaction with ongoing relationship as defined by the service categories	<p>Service categories are as follows: Evaluation categories:</p> <ul style="list-style-type: none"> <li>• Continuity of Account Management Team</li> <li>• Responsiveness regarding claims issues</li> <li>• Follow up on pending items</li> <li>• Appropriate level of training provided to                             <ul style="list-style-type: none"> <li>- Member Service Unit</li> <li>- On-Site representatives</li> <li>- Claims staff</li> </ul> </li> <li>• Accessibility of Contractor's Account Management/Executive team</li> </ul> <p>Measurement criteria: Scale: 5 = Outstanding 4 = Above Satisfactory 3 = Satisfactory 2 = Needs Improvement 1 = Unsatisfactory</p> <p>Maximum Achievable Score = 25</p> <p>Performance Guarantee at Risk: \$25,000</p> <p>Score:</p> <ul style="list-style-type: none"> <li>20 - 25 = \$0 Penalty</li> <li>15 - 19 = \$5,000 Penalty</li> <li>10 - 14 = \$15,000 Penalty</li> <li>Below 10 = \$25,000 Penalty</li> </ul>		
<b>Provider Network</b>				
Provider Turnover	Less than 7% annually	Percentage of providers who left the network voluntarily during the plan year.	<p>Awardee agrees to a Provider turnover rate of 7% or less</p> <p>Maximum Annual Penalty: \$50,000</p>	

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**Attachment 4  
Performance Guarantee Standard Provisions**

Category	Standard	Measurement	Percentage of Fees at Risk	Proposed Changes
<b>Total % of Annual Fees at Risk</b>		<b>Total Annual Dollars at Risk</b>		<b>Deviations</b>
100%		\$1,000,000		

**B. Wellness/Disease Management Programs**

The Wellness Program performance standards include disease management and are outlined over the initial three plan years, with participation and engagement guarantee being the initial focus of plan year one (2016), and health behavior and risk improvement guarantees in plan years two and three (2017 and 2018). Performance Standards for remaining plan years (2018 and 2019) will be developed through the evaluation of outcomes for initial three plan years – and will be incorporated into any resultant contract through a supplemental agreement.

Category	Standard	Measurement	Percentage of Fees at Risk	Proposed Changes
<b>Wellness/Disease Management</b>				
Participation Plan Year 1 (Jan. 1 – Dec. 31, 2016)	Over 50% participation of all Eligible Members.	At the end of the <b>first plan year</b> , program participation will exceed 50% of all Eligible Members.	Maximum Annual Penalty: 20% refund of PEPM/PPPM Fees	
Participation Plan Year 2 (Jan. 1 – Dec. 31, 2017)	Minimum of 7% of Program Participants demonstrate a minimum improvement in health behaviors/risks	At the end of the <b>second plan year</b> , improvement in health behaviors/risks of no less than 7% of Program Participants that are targeted in the Proposer behavior change campaigns, as measured by the Personal Health Assessment.  (For example: At the end of plan year two, Program participants will be 7% more physically active than when they started such Program).	Maximum Annual Penalty: 20% refund of PEPM/PPPM Fees	
Behavior/Health Risks Plan Year 3 (Jan. 1 – Dec. 31, 2018)	Savings in medical expenditures of program participants should total at least 150% of the cost to deliver Program	At the end of the <b>third plan year</b> , Program participants will have fewer medical expenditures than non-participants. The savings in expenditures should total a minimum of 150% of the cost to deliver the Program.  This is a 150% guaranteed return on investment.	Maximum Annual Penalty: 20% refund of PEPM/PPPM Fees	

**Attachment 4**  
**Performance Guarantee Standard Provisions**

Category	Standard	Measurement	Percentage of Fees at Risk	Proposed Changes
<b>Total % of Annual Fees at Risk</b>		<b>Total Annual Dollars at Risk</b>	<b>Deviations</b>	
20%		TBD		

Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 POS Plan - Non-Redesign

Proposed Plan/Deviations

	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Calendar Year Deductible</b>	Not Applicable	\$200/\$500		
<b>Medical Out-of-Pocket Maximums: Individual/Dependent Coverage</b>	\$1,500/\$4,500	\$1,500 per member		
<b>Pharmacy Out-of-Pocket Maximums: Individual/Dependent Coverage</b>	\$1,500/\$3,000	\$1,500/\$3,000		
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited		
<b>Emergency Services/Urgent Care and Immediate Care Services</b>	Member Responsibility	Member Responsibility	Member Responsibility	Member Responsibility
Emergency Room (waived if admitted) Participating and Non-Participating Hospitals	\$50 copay per visit	\$50 copay per visit		
Convenience Care Clinic Visits	\$15 copay per visit	\$50 copay per visit		
Urgent Care Center Visits	\$50 copay per visit	\$50 copay per visit		
Ambulance (When pre-authorized or in the case of emergency)	No Charge	No Charge		
<b>Prescription Drugs</b>				
Participating Pharmacy: 30-day supply at participating pharmacy (includes contraceptives)	Generic - \$15 Preferred Brand - \$25 Non-Preferred Brand - \$35	30% coinsurance		
Mail Order (MO) - 90-day supply (includes contraceptives)	Generic - \$30 Preferred Brand - \$50 Non-Preferred Brand - \$70	30% coinsurance		
Specialty Drugs (through specialty pharmacy)	Generic - \$10 Preferred Brand - \$16.66 Non-Preferred Brand - \$23.33	30% coinsurance		
<b>Inpatient Hospital Services</b>				
Inpatient Hospital Facility Services (Semi-Private Room and Board)	No Charge	30% after deductible		
Inpatient Laboratory and Diagnostic Imaging	No Charge	30% after deductible		
Physicians, Specialists and Surgeons' Services	No Charge	30% after deductible		
Anesthesia, use of Operations and Recovery Rooms, Oxygen, Drugs and Medication	No Charge	30% after deductible		
Intensive Care Unit and Other Special Units, General and Special Duty Nursing	No Charge	30% after deductible		

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Attachment 5 - Plan Designs Worksheet

Office Visits	Member Responsibility	Member Responsibility
PCP, Pediatrician, Chiropractic and Podiatry Office Visits	\$15 copay per visit	30% after deductible
Preventive Care-Routine Physicals/Pediatric Well Baby Care	No Charge	30% after deductible
Specialist Office Visits	\$30 copay per visit	30% after deductible
Annual GYN Exam when performed by Participating Specialist	No Charge	30% after deductible
Maternity Care Services	\$30 copay	30% after deductible
Prenatal and Postnatal Care	No Charge	30% after deductible
Delivery and All Inpatient Services	No Charge	30% after deductible
Allergy Injections	No Charge	30% after deductible
Allergy Treatments/Skin Testing (per course of treatment)	\$30 per visit	30% after deductible
<b>Outpatient Diagnostic Services</b>		
- Hospital Based - Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	No Charge	30% after deductible
- Non-Hospital Based - Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	No Charge	30% after deductible
- Hospital Based - Other Diagnostic Imaging Tests and Laboratory	No Charge	30% after deductible
- Non-Hospital Based - Other Diagnostic Imaging Tests and Laboratory	No Charge	30% after deductible
- Hospital Based - Mammogram	No Charge	30% after deductible
- Non-Hospital Based - Mammogram	No Charge	30% after deductible
<b>Outpatient Services</b>		
Outpatient Surgeries, including cardiac catheterizations and angioplasty	No Charge, except \$200 for physician/surgeon copay for infertility surgery	30% after deductible
<b>Mental/Nervous Disorder's Health Care</b>		
Inpatient	No Charge	30% after deductible
Outpatient	\$15 copay per visit	30% after deductible
<b>Drug and Alcohol Rehabilitation Programs</b>		
Inpatient	No Charge	30% after deductible
Outpatient	\$15 copay per visit	30% after deductible

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Attachment 5 - Plan Designs Worksheet

<p><b>Physical, Speech, Respiratory and Occupational Therapies</b> Short Term is limited to 60 days combined per Calendar Year; 36 visits per calendar year for Cardiac Rehab.</p>	<p>\$30 copay per visit</p>	<p>30% after deductible</p>		
<p><b>Home Health Care</b></p>	<p>No Charge</p>	<p>30% after deductible</p>		
<p><b>Skilled Nursing Care</b> Limited to 60 days per calendar year.</p>	<p>No Charge</p>	<p>30% after deductible</p>		
<p><b>Hospice Care</b> Limited to 360 days per member lifetime maximum.</p>	<p>No Charge</p>	<p>30% after deductible</p>		
<p><b>Durable Medical Equipment</b> Equipment includes but not limited to: Hospital Beds, Walkers, Crutches, Wheelchairs</p>	<p>No Charge/Device for DME and Orthotics; No Charge for External Prosthetic Appliance, after \$200 contract year deductible</p>	<p>30% after deductible</p>		
<p><b>Diagnosis and Treatment of Vision, Speech and Hearing Disorders</b></p>			<p>Member Responsibility</p>	<p>Member Responsibility</p>
<p>Habilitative Physical, Occupational and Speech Therapy Services are covered to a combined maximum of 100 visits per Calendar Year.</p>				
<p>Applied Behavioral Analysis</p>	<p>\$15 copay per visit</p>	<p>30% after deductible</p>		
<p>Physical, Speech, Occupational Therapy</p>	<p>\$15 copay per visit</p>	<p>30% after deductible</p>		
<p><b>Other</b></p>				
<p>Inertility (Limited to testing and treatment for services performed in conjunction with an underlying medical condition, testing performed exclusively to determine the cause of infertility, and treatment and/or procedures exclusively to restore fertility (e.g. procedures to correct infertility condition). Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments are not covered.</p>	<p>\$30 copay per visit \$200 Surgical copay applies for Inertility Surgery</p>	<p>30% after deductible</p>		
<p>Bariatric Surgery</p>	<p>Covered</p>	<p>Covered</p>		
<p>Acupuncture</p>	<p>Not Covered</p>	<p>30% after deductible</p>		
<p>Glasses</p>	<p>Not Covered</p>	<p>Not Covered</p>		
<p>Dental Check-Up</p>	<p>Not Covered</p>	<p>Not Covered</p>		
<p>Eye Exam Limited to 1 exam per year to determine the need for sight correction.</p>	<p>\$15 copay per visit</p>	<p>30% after deductible</p>		
<p>Hearing Aids</p>	<p>Not Covered</p>	<p>Not Covered</p>		

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
POS Plan - Redesign

Proposed Plan/Deviations

	In-Network	Out-of-Network*	In-Network	Out-of-Network
<b>Calendar Year Deductible</b>	Not Applicable	\$200/\$500		
<b>Out-of-Pocket Maximums: Individual/Dependent Coverage</b>	\$3,000/\$6,000	\$3,000/\$6,000		
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited		
<b>Emergency Services/Urgent Care and Immediate Care Services</b>	Member Responsibility	Member Responsibility	Member Responsibility	Member Responsibility
Emergency Room (waived if admitted) Participating and Non-Participating Hospitals	\$100 copay per visit	\$100 copay per visit		
Convenience Care Clinic Visits	\$15 copay per visit	\$15 copay per visit		
Urgent Care Center Visits	\$50 copay per visit	\$50 copay per visit		
Ambulance (When pre-authorized or in the case of emergency)	No Charge	No Charge		
<b>Prescription Drugs</b>				
Participating Pharmacy: 30-day supply at participating pharmacy (includes contraceptives)	Generic - \$15 Preferred Brand - \$40 Non-Preferred Brand - \$55	30% Coinsurance		
Mail Order (MO) - 90-day supply (includes contraceptives)	Generic - \$30 Preferred Brand - \$80 Non-Preferred Brand - \$110	30% Coinsurance		
Specialty Drugs (through specialty pharmacy) - Retail	\$100 copay	30% Coinsurance		
<b>Inpatient Hospital Services</b>				
Inpatient Hospital Facility Services (Semi-Private Room and Board)	\$200 copay per admission No Charge at Jackson Health System facility	30% after deductible		
Inpatient Laboratory and Diagnostic Imaging	\$100 copay; No copay if part of inpatient hospitalization	30% after deductible		
Physicians, Specialists and Surgeons' Services	No Charge	30% after deductible		
Anesthesia, use of Operations and Recovery Rooms, Oxygen, Drugs and Medication	No Charge	30% after deductible		
Intensive Care Unit and Other Special Units, General and Special Duty Nursing	No Charge	30% after deductible		

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Attachment 5 - Plan Designs Worksheet

Office Visits	Member Responsibility	Member Responsibility	Member Responsibility
PCP, Pediatrician, Chiropractic and Podiatry Office Visits	\$15 copay per visit	30% after deductible	
Preventive Care-Routine Physicals/Pediatric Well Baby Care	No Charge	30% after deductible	
Specialist Office Visits	\$30 copay per visit	30% after deductible	
Annual GYN Exam when performed by Participating Specialist	No Charge	30% after deductible	
Maternity Care Services Initial Visit	\$30 copay/first visit only	30% after deductible	
Delivery and All Inpatient Services	\$200 copay per admission; No Charge at Jackson Health System	30% after deductible	
Allergy Injections	\$30 per visit	30% after deductible	
Allergy Treatments/Skin Testing (per course of treatment)	\$30 per visit	30% after deductible	
<b>Outpatient Diagnostic Services</b>			
- Hospital Based - Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	\$100 copay per test at hospital-based facility No copay at Jackson Health System	30% after deductible	
- Non-Hospital Based - Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	No Charge	30% after deductible	
- Hospital Based - Other Diagnostic Imaging Tests and Laboratory	\$100 copay per test at hospital-based facility No copay at Jackson Health System	30% after deductible	
- Non-Hospital Based - Other Diagnostic Imaging Tests and Laboratory	No Charge	30% after deductible	
- Hospital Based - Mammogram - Diagnostic-Related Services	\$100 copay per test at hospital-based facility No copay at Jackson Health System facility	30% after deductible	
- Preventive Care	No Charge	30% after deductible	
- Non-Hospital Based - Mammogram	No Charge	30% after deductible	
<b>Outpatient Services</b>			
Outpatient Surgeries, including cardiac catheterizations and angioplasty	\$100 copay at Hospital-based facility; No copay at Jackson Health System facility or non-hospital-based facility	30% after deductible	

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RFP No. 00196

Mental/Nervous Disorders Health Care	Member Responsibility	Member Responsibility
Inpatient	\$200 copay per admission; no copay at Jackson Health System facility	30% after deductible
Outpatient	\$15 copay per visit	30% after deductible
Drug/Alcohol Rehabilitation Programs	\$200 copay per admission; no copay at Jackson Health System facility	30% after deductible
Outpatient	\$15 copay per visit	30% after deductible
Physical, Speech, Respiratory and Occupational Therapies Short Term is limited to 60 days combined per Calendar Year, 36 visits per calendar year for Cardiac Rehab.	\$30 copay per visit	30% after deductible
Home Health Care Limited to 60 visits maximum per contract year.	No Charge	30% after deductible
Skilled Nursing Care Limited to 60 days per calendar year.	No Charge	30% after deductible
Hospice Care Limited to 360 days per member lifetime maximum.	No Charge	30% after deductible
Durable Medical Equipment Equipment includes but not limited to: Hospital Beds, Walkers, Crutches, Wheelchairs	No Charge per device for DME and Orthotics; No charge for external prosthetic appliance, after \$200 contract year deductible.	30% after deductible for DME and Orthotics
Diagnosis and Treatment of Autism Spectrum Disorder		Member Responsibility
Habilitative Physical, Occupational and Speech Therapy Services are covered to a combined maximum of 100 visits per Calendar Year.		Member Responsibility
Applied Behavioral Analysis	\$15 copay per visit	30% after deductible
Physical, Speech, Occupational Therapy	\$15 copay per visit	30% after deductible

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Attachment 5 - Plan Designs Worksheet

Other	\$30 copay per visit	\$200 Surgical copay applies for Infertility Surgery.	30% after deductible
In fertility treatment is limited to testing and treatment for services performed in conjunction with an underlying medical condition, testing performed exclusively to determine the cause of infertility, and treatment and/or procedures exclusively to restore fertility (e.g. procedures to correct infertility condition). Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments are not covered.			
Bariatric Surgery	Covered		Covered
Acupuncture	Not Covered		30% after deductible
Glasses	Not Covered		Not Covered
Dental Check-Up	Not Covered		Not Covered
Eye Exam	Not Covered		Not Covered
Hearing Aid	Not Covered		Not Covered

\*Note: Out-of-Network - Plan pays 70% of Maximum Allowable Payment (MAP)

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
High HMO Plan - Redesign

		Proposed Plan/Deviations
Calendar Year Deductible	Not Applicable	
Out-Of-Pocket Maximums: Individual / Dependent Coverage	\$3,000/\$6,000	
Lifetime Maximum Benefit	Unlimited	
Open Access/No Referral	Yes	
<b>Emergency Services/Urgent Care and Immediate Care Services</b>	<b>Member Responsibility</b>	<b>Member Responsibility</b>
Emergency Room (waived if admitted) Participating and Non-Participating Hospitals (In Network and Out of Network)	\$100 copay per visit	
Convenience Care Clinic Visits / Retail Clinics (In Network and Out of Network)	\$15 copay per visit	
Urgent Care Center Visits (In Network and Out of Network)	\$25 copay per visit	
Ambulance (When pre-authorized or in the case of emergency) (In Network and Out of Network)	No Charge	
<b>Prescription Drugs</b>		
Participating Pharmacy: 30-day supply at participating pharmacy (includes contraceptives)	Generic - \$15 Preferred Brand - \$40 Non-Preferred Brand - \$55	
Mail Order (MO) - 90-day supply (includes contraceptives)	Generic - \$30 Preferred Brand - \$80 Non-Preferred Brand - \$110	
Specialty Drugs (through specialty pharmacy) - Retail	\$100 copay	
<b>Inpatient Hospital Services</b>	<b>Member Responsibility</b>	<b>Member Responsibility</b>
Inpatient Hospital Facility Services (Semi-Private Room and Board)	\$200 copay per admission No Charge at JHS facility	
Inpatient Laboratory and Diagnostic Imaging	\$100 copay; No copay if part of inpatient hospitalization	
Physicians, Specialists and Surgeons' Services	No Charge	

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
High HMO Plan - Redesign

		Proposed Plan/Deviations
Anesthesia, use of Operations and Recovery Rooms, Oxygen, Drugs and Medication	No Charge	
Intensive Care Unit and Other Special Units, general and Special Duty Nursing	No Charge	
<b>Office Visits</b>	<b>Member Responsibility</b>	<b>Member Responsibility</b>
PCP, Pediatrician, Chiropractic and Podiatry Office Visits	\$15 copay per visit	
Preventive Care-Routine Physicals/Pediatric Well Baby Care	No Charge	
Specialist Office Visits	\$30 copay per visit	
Annual GYN Exam when performed by participating specialist	No Charge	
Maternity Care Services	\$30 copay/first visit only	
Initial Visit	\$200 copay per admission; No Charge at Jackson Health System	
Delivery and All Inpatient	\$15 per visit	
Allergy Injections	\$30 per visit	
Allergy Treatments/Skin Testing (per course of treatment)		
<b>Outpatient Diagnostic Services</b>		
- Hospital Based - Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	\$100 copay per test at hospital-based facility No copay at Jackson Health System	
- Non-Hospital Based - Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	No Charge	
- Hospital Based - Other Diagnostic Imaging Tests and Laboratory	\$100 copay per test at hospital-based facility No copay at Jackson Health System	
- Non-Hospital Based - Other Diagnostic Imaging Tests and Laboratory	No Charge	

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
High HMO Plan - Redesign

Proposed Plan/Deviations

- Hospital Based - Mammogram - Diagnostic-Related Services	\$100 copay per test at hospital-based facility No copay at Jackson Health System
- Preventive Care	No Charge
- Non-Hospital Based - Mammogram	No Charge
<b>Outpatient Services</b>	
Outpatient surgeries, including cardiac catheterizations and angioplasty	\$100 copay at hospital-based facility; No copay at Jackson Health System facility or non-hospital-based facility
<b>Mental/Nervous Disorders Health Care</b>	
Inpatient	\$200 copay per admission; no copay at Jackson Health System facility
Outpatient	\$15 copay per visit
<b>Drug and Alcohol Rehabilitation Programs</b>	
Inpatient	\$200 copay per admission; no copay at Jackson Health System facility
Outpatient	\$15 copay per visit
<b>Physical, Speech, Respiratory and Occupational Therapies</b> Short Term is limited to 60 visits combined per Calendar Year; 36 visits per calendar year for Cardiac Rehab.	\$30 per visit
<b>Home Health Care</b>	No Charge
<b>Skilled Nursing Care</b> Limited to 60 days per Calendar Year.	No Charge
<b>Hospice Care</b> Limited to 360 day per member lifetime maximum	No Charge
<b>Durable Medical Equipment</b> Equipment includes but not limited to: Hospital Beds, Walkers, Crutches, Wheelchairs	\$50 copay per episode of illness for DME or Orthotic Appliances; No Charge/Device for Prosthetic Devices

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
High HMO Plan - Redesign

Proposed Plan/Deviations

Diagnosis and Treatment of Autism Spectrum Disorder	
Habilitative Physical, Occupational and Speech Therapy Services are covered to a combined maximum of 100 visits per Calendar Year.	\$15 per visit
Applied Behavioral Analysis	\$15 per visit
Physical, Speech, Occupational Therapy	\$30 copay per visit
<p>Inferility</p> <p>Inferility treatment is limited to one sequence per member lifetime for the following: sperm count, endometrial biopsy, hysterosalpingography (HSG), and diagnostic laparoscopy. Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other inferility treatments are not covered.</p>	Not Covered
Bariatric Surgery	Not Covered
Acupuncture	Not Covered
Glasses	Not Covered
Dental Check-Up	Not Covered
<p>Eye Exam</p> <p>if your child needs eye care Limited to 1 exam per year to determine the need for sight correction.</p>	\$15 copay
Hearing Aids	Not Covered

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 High HMO Plan - Non-Redesign

		Proposed Plan/Deviations
Calendar Year Deductible		Not Applicable
Medical Out-of-Pocket Maximums: Individual/Dependent Coverage		\$1,500/\$3,000
Pharmacy Out-of-Pocket Maximums: Individual/Dependent Coverage		\$1,500/\$3,000
Lifetime Maximum Benefit		Unlimited
Open Access/No Referral		Yes
Emergency Services/Urgent Care and Immediate Care Services		Member Responsibility
Emergency Room (waived if admitted) Participating and Non-Participating Hospitals (In Network and Out of Network)		\$25 copay per visit
Convenience Care Clinic Visits (In Network and Out of Network)		\$15 copay per visit - In Network \$50 copay per visit - Out of Network
Urgent Care Center Visits (In Network and Out of Network)		\$25 copay per visit - In Network \$50 copay per visit - Out of Network
Ambulance (When pre-authorized or in the case of emergency) (In Network and Out of Network)		No copay
Prescription Drugs		
Participating Pharmacy: 30-day supply at participating pharmacy (includes contraceptives)		Generic - \$15 Preferred Brand - \$25 Non-Preferred Brand - \$35
Mail Order (MO) - 90-day supply (includes contraceptives)		Generic - \$30 Preferred Brand - \$50 Non-Preferred Brand - \$70
Specialty Drugs (through specialty pharmacy) - Retail		Generic - \$15 Preferred Brand - \$25 Non-Preferred Brand - \$35

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
High HMO Plan - Non-Redesign

		Proposed Plan/Deviations	
Inpatient Hospital Services	Member Responsibility	Member Responsibility	Member Responsibility
Inpatient Hospital Facility Services (Semi-Private Room and Board)	No Charge		
Inpatient Laboratory and Diagnostic Imaging	No Charge		
Physicians, Specialists and Surgeons' Services	No Charge		
Anesthesia, use of Operations and Recovery Rooms, Oxygen, Drugs and Medication	No Charge		
Intensive Care Unit and Other Special Units, General and Special Duty Nursing	No Charge		
<b>Office Visits</b>	<b>Member Responsibility</b>	<b>Member Responsibility</b>	<b>Member Responsibility</b>
PCP, Pediatrician, Chiropractic and Podiatry Office Visits	\$15 copay per visit		
Preventive Care-Routine Physicals/Pediatric Well Baby Care	No Charge		
Specialist Office Visits	\$30 copay per visit		
Annual GYN Exam when performed by Participating Specialist	No Charge		
Maternity Care Services	\$30 copay/first visit only		
Prenatal and Postnatal Care	No Charge		
Delivery and All Inpatient Services	No Charge		
Allergy Injections	\$15 per visit		
Allergy Treatments/Skin Testing (per course of treatment)	\$30 per visit		
<b>Outpatient Diagnostic Services</b>	<b>Member Responsibility</b>	<b>Member Responsibility</b>	<b>Member Responsibility</b>
- Hospital Based - Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	No Charge		
- Non-Hospital Based - Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	No Charge		
- Hospital Based - Other Diagnostic Imaging Tests and Laboratory	No Charge		

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 High HMO Plan - Non-Redesign

Proposed Plan/Deviations

- Non-Hospital Based - Other Diagnostic Imaging Tests and Laboratory	No Charge	
- Hospital Based - Mammogram	No Charge	
- Non-Hospital Based - Mammogram	No Charge	
<b>Outpatient Services</b>	<b>Member Responsibility</b>	<b>Member Responsibility</b>
Outpatient Surgeries, including cardiac catheterizations and angioplasty	No Charge	
<b>Mental/Nervous Disorders Health Care</b>		
Inpatient	No Charge	
Outpatient	\$15 copay per visit	
<b>Drug and Alcohol Rehabilitation Programs</b>		
Inpatient	No Charge	
Outpatient	\$15 copay per visit	
<b>Physical, Speech, Respiratory and Occupational Therapies</b>	\$30 copay per visit	
Short Term is limited to 60 days combined per Calendar Year; 36 visits per calendar year for Cardiac Rehab.		
<b>Home Health Care</b>	No Charge	
<b>Skilled Nursing Care</b>	No Charge	
Limited to 60 days per calendar year.		
<b>Hospice Care</b>	No Charge	
Limited to 360 days per member lifetime maximum.		
<b>Durable Medical Equipment</b>	\$50 copay per episode of illness for DME or Orthotic Appliances; No Charge/Device for Prosthetic Devices	
Equipment includes but not limited to: Hospital Beds, Walkers, Crutches, Wheelchairs		
<b>Diagnosis and Treatment of Autism Spectrum Disorder</b>		
Habilitative Physical, Occupational and Speech Therapy Services are covered to a combined maximum of 100 visits per Calendar Year.		
Applied Behavioral Analysis	\$15 copay per visit	

Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
High HMO Plan - Non-Redesign

Proposed Plan/Deviations

Physical, Speech, Occupational Therapy	\$15 copay per visit	
Other		
Infertility Limited to one sequence per member lifetime for the following: sperm count, endometrial biopsy, hysterosalpingography (HSG), and diagnostic laparoscopy. Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments are not covered.	\$30 copay per visit	
Bariatric Surgery	Not Covered	
Acupuncture	Not Covered	
Glasses	Not Covered	
Dental Check-Up	Not Covered	
Eye Exam Limited to 1 exam per year to determine the need for sight correction.	\$15 copay per visit	
Hearing Aids	Not Covered	

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
HMO Select Plan - Redesign

		Proposed Plan/Deviations
Calendar Year Deductible		Not Applicable
Out-of-Pocket Maximums: Individual/Dependent Coverage		\$2,500/\$5,000
Lifetime Maximum Benefit		Unlimited
Open Access/No Referral Needed		Yes
Emergency Services/Urgent Care and Immediate Care Services		Member Responsibility
Emergency Room (waived if admitted) Participating and Non-Participating Hospitals		\$50 copay per visit
Convenience Care Clinic Visits (In Network/Out of Network)		\$15 copay per visit
Urgent Care Center Visits (In Network/Out of Network)		\$25 copay per visit
Ambulance (When pre-authorized or in the case of emergency) (In Network/Out of Network)		No copay
Prescription Drugs		
Participating Pharmacy: 30-day supply at participating pharmacy (includes contraceptives)		Generic - \$15 Preferred Brand - \$25 Non-Preferred Brand - \$35
Mail Order (MO) -- 90-day supply (includes contraceptives)		Generic - \$30 Preferred Brand - \$50 Non-Preferred Brand - \$70
Specialty Drugs (through specialty pharmacy) - Retail		Generic - \$15 Preferred Brand - \$25 Non-Preferred Brand - \$35
Inpatient Hospital Services		Member Responsibility
Inpatient Hospital Facility Services (Semi-Private Room and Board)		No Charge
Inpatient Laboratory and Diagnostic Imaging		No Charge
Physicians, Specialists and Surgeons' Services		No Charge

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
HMO Select Plan - Redesign

Proposed Plan/Deviations

Anesthesia, use of Operations and Recovery Rooms, Oxygen, Drugs and Medication	No Charge	
Intensive Care Unit and Other Special Units, General and Special Duty Nursing	No Charge	
<b>Office Visits</b>	<b>Member Responsibility</b>	<b>Member Responsibility</b>
PCP, Pediatrician, Chiropractic and Podiatry Office Visits	\$15 copay per visit	
Preventive Care-Routine Physicals/Pediatric Well Baby Care	No Charge	
Specialist Office Visits	\$30 copay per visit	
Annual GYN Exam when performed by Participating Specialist	No Charge	
Maternity Care Services	\$30 copay/first visit only	
Initial Visit	No Charge	
Delivery and All Inpatient	\$15 per visit	
Allergy Injections	\$30 per visit	
Allergy Treatments/Skin Testing (per course of treatment)		
<b>Outpatient Diagnostic Services</b>	<b>Member Responsibility</b>	<b>Member Responsibility</b>
- Hospital Based - Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	No Charge	
- Non-Hospital Based - Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	No Charge	
- Hospital Based - Other Diagnostic Imaging Tests and Laboratory	No Charge	
- Non-Hospital Based - Other Diagnostic Imaging Tests and Laboratory	No Charge	
- Hospital Based - Mammogram	No Charge	
- Non-Hospital Based - Mammogram	No Charge	
<b>Outpatient Services</b>	<b>Member Responsibility</b>	<b>Member Responsibility</b>
Outpatient Surgeries, including cardiac catheterizations and angioplasty	No Charge	

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
HMO Select Plan - Redesign

Proposed Plan/Deviations

	Proposed Plan/Deviations
<b>Mental/Nervous Disorders/Health Care</b>	
Inpatient	No Charge
Outpatient	\$15 copay per visit
<b>Drug and Alcohol Rehabilitation Programs</b>	
Inpatient	No Charge
Outpatient	\$15 copay per visit
<b>Physical, Speech, Respiratory and Occupational Therapies</b>	\$30 copay per visit
Short Term is limited to 60 visits combined per Calendar Year; 36 visits per calendar year for Cardiac Rehab.	
<b>Home Health Care</b>	No Charge
<b>Skilled Nursing Care</b>	No Charge
Limited to 60 days per Calendar Year.	
<b>Hospice Care</b>	No Charge
Limited to 360 days per member lifetime maximum.	
<b>Durable Medical Equipment</b>	\$50 copay per episode of illness for DME or Orthotic Appliances; No Charge/Device for Prosthetic Devices
Equipment includes but not limited to: Hospital Beds, Walkers, Crutches, Wheelchairs	
<b>Diagnosis and Treatment of Autism Spectrum Disorder</b>	
Habilitative Physical, Occupational and Speech Therapy Services are covered to a combined maximum of 100 visits per Calendar Year.	
<b>Applied Behavioral Analysis</b>	\$15 copay per visit
Physical, Speech, Occupational Therapy	\$15 copay per visit
<b>Other</b>	

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
HMO Select Plan - Redesign

	Proposed Plan/Deviations
Infertility Infertility treatment limited to one sequence per member lifetime for the following: sperm count, endometrial biopsy, hysterosalpingo-ography (HSG), and diagnostic laparoscopy. Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments not covered.	\$30 copay per visit
Bariatric Surgery	Not Covered
Acupuncture	Not Covered
Glasses	Not Covered
Dental Check-Up	Not Covered
Eye Exam Limited to 1 exam per year to determine the need for sight correction.	\$15 copay
Hearing Aids	Not Covered

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 Low HMO Plan - Non-Redesign

		Proposed Plan/Deviations
Calendar Year Deductible		Not Applicable
Out-of-Pocket Maximums: Individual/Dependent Coverage		\$6,350/\$12,700
Lifetime Maximum Benefit		Unlimited
Open Access/No Referral		No (Gatekeeper)
Emergency Services-Urgent Care and Immediate Care Services		Member Responsibility
Emergency Room (waived if admitted) Participating and Non-Participating Hospitals (In Network and Out of Network)		\$100 copay per visit
Convenience Care Clinic Visits (In Network and Out of Network)		\$30 copay per visit - In Network \$50 copay per visit - Out of Network
Urgent Care Center Visits (In Network and Out of Network)		\$50 copay per visit
Ambulance (When pre-authorized or in the case of emergency) (In Network and Out of Network)		No Charge
Prescription Drugs		
Participating Pharmacy: 30-day supply at participating pharmacy (includes contraceptives)		Generic - \$20 Preferred Brand - \$35 Non-Preferred Brand - \$55
Mail Order (MO) - 90-day supply (includes contraceptives)		Generic - \$40 Preferred Brand - \$70 Non-Preferred Brand - \$110
Specialty Drugs (through specialty pharmacy) - Retail		Generic - \$20 Preferred Brand - \$35 Non-Preferred Brand - \$55

Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
Low HMO Plan - Non-Redesign

Proposed Plan/Deviations	
Inpatient Hospital Services	Member Responsibility
Inpatient Hospital Facility Services (Semi-Private Room and Board)	
Inpatient Laboratory and Diagnostic Imaging	
Physicians, Specialists and Surgeons' Services	\$150 copay per day for first 3 days, per admission
Anesthesia, use of Operations and Recovery Rooms, Oxygen, Drugs and Medication	
Intensive Care Unit and Other Special Units, General and Special Duty Nursing	
<b>Office Visits</b>	<b>Member Responsibility</b>
PCP, Pediatrician, Chiropractic and Podiatry Office Visits	\$30 copay per visit
Preventive Care-Routine Physicals/Pediatric Well Baby Care	No Charge
Specialist Office Visits	\$45 copay per visit
Annual GYN Exam when performed by Participating Specialist	No Charge
Maternity Care Services	\$45 copay/first visit only
Prenatal and Postnatal Care	\$150 copay per day for first 3 days, per admission
Delivery and All Inpatient Services	
Allergy Injections	
Allergy Treatments/Skin Testing (per course of treatment)	\$30 per visit \$45 per visit
<b>Outpatient Diagnostic Services</b>	
- Hospital Based - Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	No Charge
- Non-Hospital Based - Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	No Charge

Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
Low HMO Plan - Non-Redesign

Proposed Plan/Deviations

- Hospital Based - Other Diagnostic Imaging Tests and Laboratory	No Charge	
- Non-Hospital Based - Other Diagnostic Imaging Tests and Laboratory	No Charge	
- Hospital Based - Mammogram	No Charge	
- Non-Hospital Based - Mammogram	No Charge	
<b>Outpatient Services</b>	<b>Member Responsibility</b>	<b>Member Responsibility</b>
Outpatient Surgeries, including cardiac catheterizations and angioplasty	No Charge	
<b>Mental/Nervous Disorders Health Care</b>		
Inpatient	\$150 copay per day for first 3 days, per admission	
Outpatient	\$30 copay per visit	
<b>Drug/Alcohol Rehabilitation Programs</b>		
Inpatient	\$150 copay per day for first 3 days, per admission	
Outpatient	\$30 copay per visit	
<b>Physical, Speech, Respiratory and Occupational Therapies</b> Short Term is limited to 60 days combined per Calendar Year, 36 visits per calendar year for Cardiac Rehab.	\$45 copay per visit	
<b>Home Health Care</b>	No Charge	
<b>Skilled Nursing Care</b> Limited to 60 days per calendar year.	No Charge	
<b>Hospice Care</b> Limited to 360 days per member lifetime maximum.	No Charge	

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 Low HMO Plan - Non-Redesign

Proposed Plan/Deviations

<p><b>Durable Medical Equipment</b>                  Equipment includes but not limited to: Hospital Beds, Walkers, Crutches, Wheelchairs</p>	<p>\$50 copay per episode of illness for DME or Orthotic Appliances; No Charge/Device for Prosthetic Devices</p>	
<p><b>Diagnosis and Treatment of Autism Spectrum Disorder</b></p>		
<p>Habilitative Physical, Occupational and Speech Therapy Services are covered to a combined maximum of 100 visits per Calendar Year.</p>		
<p>Applied Behavioral Analysis</p>	<p>\$30 copay per visit</p>	
<p>Physical, Speech, Occupational Therapy</p>	<p>\$30 copay per visit</p>	
<p><b>Other</b></p>		
<p>Infertility                  Limited to one sequence per member lifetime for the following: sperm count, endometrial biopsy, hysterosalpingo-graphy (HSG), and diagnostic laparoscopy. Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments are not covered.</p>	<p>\$45 copay per visit</p>	
<p>Bariatric Surgery</p>	<p>Not Covered</p>	
<p>Acupuncture</p>	<p>Not Covered</p>	
<p>Glasses</p>	<p>Not Covered</p>	
<p>Dental Check-Up</p>	<p>Not Covered</p>	
<p>Eye Exam                  Limited to 1 exam per year to determine the need for sight correction.</p>	<p>\$30 copay per visit</p>	
<p>Hearing Aids</p>	<p>Not Covered</p>	

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 Medicare Retiree High HMO Plan With Rx

Proposed Plan/Deviations

Calendar Year Deductible	\$147 for Private Duty Nursing/Per Individual \$250 for Foreign Travel Emergency Care/Per Individual	Member Responsibility
Out-Of-Pocket Maximums: Individual / Dependent Coverage	N/A	Member Responsibility
Lifetime Maximum Benefit	Unlimited	Member Responsibility
Medicare Part B Deductible: \$147 Per Calendar Year	Not Covered	Member Responsibility
Choice of Hospitals	Unlimited	Member Responsibility
Emergency Services/Urgent Care Services		Member Responsibility
Emergency and Urgent Care Services Covered by Medicare Part B	Remainder 20% of Medicare approved amount	Member Responsibility
Ambulance Covered by Medicare Part B	Remainder 20% of Medicare approved amount	Member Responsibility
Prescription Drugs		Member Responsibility
Participating Pharmacy: 30-day supply at participating pharmacy - Retail	80% after \$200 calendar year deductible	Member Responsibility
Mail Order (MO) – 90-day supply at participating pharmacy (includes contraceptives)	Generic - \$10 copay Preferred Brand - \$20 copay Non-Preferred Brand - \$30 copay	Member Responsibility
Specialty Drugs: 30-day supply at participating specialty pharmacy	\$100 copay per prescription	Member Responsibility
Inpatient Hospital Services		Member Responsibility

Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 Medicare Retiree High HMO Plan With Rx

Proposed Plan/Deviations

<p>Inpatient Hospital Facility Services (Semi-Private Room and Board)                  Covered by Medicare Part A. Medicare covers:                  Days 1-60: All but \$1,260                  Days 61-90: All but \$315 per day                  Days 91-150: All but \$630 per day                  *Days 91-150 are the 60 Lifetime Reserve Days. Medicare will cease until a new Benefit Period begins. A new Benefit Period begins after you have been out of the hospital or facility for at least 60 days. In a new Benefit Period, all Medicare Part A will renew except for the Lifetime Reserve Days.</p>	<p>100% up to \$1,260                  100% up to \$315 per day                  100% up to \$630 per day                  *365 additional lifetime days after Medicare Lifetime Reserve Days are exhausted                  Covered at 100% of Medicare eligible expense                  Must be medically necessary                  Limiting semi-private room (unless medically necessary) and board amount</p>	
<p>X-Rays                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	
<p>Surgical Procedures                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	
<p>Office Visits                  Physician's Office Visit                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	
<p>Preventive Care                  Covered by Medicare Part B</p>	<p>No Charge</p>	
<p>Subject to Preventive Care guidelines outlined in the "2015 Medicare &amp; Your" publication from Centers for Medicare &amp; Medicaid Services (CMS)</p>		
<p>Specialist Office Visits                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	
<p>Allergy injections                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	

Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 Medicare Retiree High HMO Plan With Rx

Proposed Plan/Deviations	
Maternity Care Services - Covered by Medicare Part B Initial Visit to confirm pregnancy/All subsequent prenatal and postnatal visits  Delivery and All Inpatient - Covered by Medicare Part A (Inpatient Hospital or Birthing Center)	Remainder 20% of Medicare approved amount  Days 1 to 60: 100% up to \$1,250 Days 61 to 90: 100% up to \$315 per day Days 91 - 150: 100% up to \$630 per day
Complex Radiological Imaging (CT, MRI, MRA, PET) Covered by Medicare Part B	Remainder 20% of Medicare approved amount
<b>Outpatient Services</b>	
Hospital Outpatient/Physician Covered by Medicare Part B	Remainder 20% of Medicare approved amount
Outpatient Facility Covered by Medicare Part B Services in Operating and Recover Room, Procedures Room and Treatment	Remainder 20% of Medicare approved amount
Outpatient Surgical Facility Covered by Medicare Part B Surgical sterilization procedures for Vasectomy/Tubal Ligations	Remainder 20% of Medicare approved amount
<b>Mental/Nervous Disorders Health Care</b>	
Inpatient Covered by Medicare Part A Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1	Plan pays 100% of amount approved but not paid by Medicare; if charges not approved by Medicare, there is no coverage.

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 Medicare Retiree High HMO Plan With Rx

Proposed Plan/Deviations

<p>Outpatient                  Covered by Medicare Part B</p>	<p>Coverage assumes enrollment in Medicare Part B; Plan pays remainder of charges approved by not paid by Medicare Part B and member has \$0 responsibility</p>	
<p><b>Drug and Alcohol Rehabilitation Programs</b>                  Inpatient                  Covered by Medicare Part A                  Acute detoxification: requires 24-hour nursing; based on a ratio of 1:1                  Acute Inpatient Rehab: requires 24-hour nursing; based on a ratio of 1:1                  Partial: based on a ratio of 2:1                  Residential: based on a ratio of 2:1</p>	<p>Plan pays 100% of amount approved but not paid by Medicare; if charges not approved by Medicare, there is no coverage.</p>	
<p>Outpatient                  Covered by Medicare Part B</p>	<p>Coverage assumes enrollment in Medicare Part B; Plan pays remainder of charges approved by not paid by Medicare Part B and member has \$0 responsibility</p>	
<p><b>Physical Therapy Services</b>                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	
<p><b>Short-Term Rehabilitation</b>                  Covered by Medicare Part B                  Includes:                  - Cardiac Rehab                  - Speech Therapy                  - Occupational Therapy                  - Pulmonary Rehab                  - Cognitive Therapy                  - Chiropractic Therapy (includes Chiropractors)</p>	<p>Remainder 20% of Medicare approved amount Limited to \$1,940 per calendar year for Physical Therapy (PT) and Speech Therapy Language Pathology (SLP) services combined; Limited to \$1,940 per calendar year for Occupational Therapy services</p>	

Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 Medicare Retiree High HMO Plan With Rx

Proposed Plan/Deviations

<p><b>Home Health Care</b>                  When covered by Medicare                  When not covered by Medicare</p>	<p>No Charge                  Plan will pay up to \$40 per visit limited to \$1,600 per calendar year</p>	
<p><b>Private Duty Nursing</b>                  Covered by Medicare Part B                  (While Inpatient Hospital or Other Health Care Facility Only)</p>	<p>80% of the Reasonable &amp; Customary charges after \$147 calendar year deductible</p>	
<p><b>Hospice Care</b>                  Inpatient Services                  Outpatient Services (same coinsurance level as Home Health Care)</p>	<p>Plan pays 100% of amount approved but not paid by Medicare; when Medicare certification and election requirements are met.</p>	
<p><b>Skilled Nursing Facilities</b>                  Days 1-20: Covered by Medicare Part A                  Days 21-100: Covered all but \$157.50 per day</p>	<p>Days 1-20: Not Covered                  Days 21-100: 100% up to \$157.50 per day                  Days 101 &amp; Beyond: Not Covered</p>	
<p><b>Durable Medical Equipment and External Prosthesis</b>                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	
<p><b>Other</b>                  Infertility - Office Visit for Diagnosis                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	
<p>Bariatric Surgery</p>	<p>Not Covered</p>	
<p>Acupuncture</p>	<p>Not Covered</p>	
<p>Glasses</p>	<p>Not Covered</p>	
<p>Covered by Medicare Part B</p>	<p>Not Covered</p>	
<p>Dental Check-Up</p>	<p>Not Covered</p>	
<p>Eye Exam</p>	<p>Not Covered</p>	
<p>Hearing Aids</p>	<p>Not Covered</p>	

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 Medicare Retiree High HMO Plan Without Rx

Proposed Plan/Deviations

Calendar Year Deductible	\$147 for Private Duty Nursing/Per Individual \$250 for Foreign Travel Emergency Care/Per Individual	
Out-Of-Pocket Maximums: Individual / Dependent Coverage	N/A	
Lifetime Maximum Benefit	Unlimited	
Medicare Part B Deductible: \$147 Per Calendar Year	Not Covered	
Choice of Hospitals	Unlimited	
Emergency Services/Urgent Care Services	Member Responsibility	Member Responsibility
Emergency and Urgent Care Services Covered by Medicare Part B	Remainder 20% of Medicare approved amount	
Ambulance Covered by Medicare Part B	Remainder 20% of Medicare approved amount	
Prescription Drugs		
Participating Pharmacy: 30-day supply at participating pharmacy - Retail	Not Covered	
Mail Order (MO) - 90-day supply at participating pharmacy (includes contraceptives)	Not Covered	
Specialty Drugs: 30-day supply at participating specialty pharmacy	Not Covered	
Inpatient Hospital Services	Member Responsibility	Member Responsibility

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 Medicare Retiree High HMO Plan Without Rx

Proposed Plan/Deviations

<p>Inpatient Hospital Facility Services (Semi-Private Room and Board)                  Covered by Medicare Part A. Medicare covers:                  Days 1-60: All but \$1,260                  Days 61-90: All but \$315 per day                  Days 91-150: All but \$630 per day                  *Days 91-150 are the 60 Lifetime Reserve Days. Medicare will cease until a new Benefit Period begins. A new Benefit period begins after you have been out of the hospital or facility for at least 60 days. In a new Benefit Period, all Medicare Part A will renew except for the Lifetime Reserve Days.</p>	<p>100% up to \$1,260                  100% up to \$315 per day                  100% up to \$630 per day                  *365 additional lifetime days after Medicare Lifetime Reserve Days are exhausted                  Covered at 100% of Medicare eligible expense                  Must be medically necessary                  Limiting semi-private room (unless medically necessary) and board amount</p>	
<p>X-Rays                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	
<p>Surgical Procedures                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	
<p><b>Office Visits</b>                  Physician's Office Visit                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	
<p>Preventive Care                  Covered by Medicare Part B</p>	<p>No Charge</p>	
<p>Subject to Preventive Care guidelines outlined in the "2015 Medicare &amp; Your" publication from Centers for Medicare &amp; Medicaid Services (CMS)                  Specialist Office Visits                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	
<p>Allergy Injections                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 Medicare Retiree High HMO Plan Without Rx

Proposed Plan/Deviations

Maternity Care Services - Covered by Medicare Part B Initial Visit to confirm pregnancy/All subsequent prenatal and postnatal visits  Delivery and All Inpatient - Covered by Medicare Part A (Inpatient Hospital or Birthing Center)	Remainder 20% of Medicare approved amount  Days 1 to 60: 100% up to \$1,250 Days 61 to 90: 100% up to \$315 per day Days 91 - 150: 100% up to \$630 per day	
Complex Radiological Imaging (CT, MRI, MRA, PET) Covered by Medicare Part B	Remainder 20% of Medicare approved amount	
Outpatient Services Hospital Outpatient/Physician Covered by Medicare Part B	Remainder 20% of Medicare approved amount	
Outpatient Facility Covered by Medicare Part B Services in Operating and Recover Room, Procedures Room and Treatment	Remainder 20% of Medicare approved amount	
Outpatient Surgical Facility Covered by Medicare Part B Surgical sterilization procedures for Vasectomy/Tubal Ligations	Remainder 20% of Medicare approved amount	
Mental/Nervous Disorders Health Care Inpatient Covered by Medicare Part A Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1	Plan pays 100% of amount approved but not paid by Medicare; if charges not approved by Medicare, there is no coverage.	

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 Medicare Retiree High HMO Plan Without Rx

Proposed Plan/Deviations

<p>Outpatient                  Covered by Medicare Part B</p>	<p>Coverage assumes enrollment in Medicare Part B;                  Plan pays remainder of charges approved by not paid by Medicare Part B and member has \$0 responsibility</p>
<p><b>Drug and Alcohol Rehabilitation Programs</b>                  Inpatient                  Covered by Medicare Part A                  Acute detoxification: requires 24-hour nursing; based on a ratio of 1:1                  Acute Inpatient Rehab: requires 24-hour nursing; based on a ratio of 1:1                  Partial: based on a ratio of 2:1                  Residential: based on a ratio of 2:1</p>	<p>Plan pays 100% of amount approved but not paid by Medicare; if charges not approved by Medicare, there is no coverage.</p>
<p>Outpatient                  Covered by Medicare Part B</p>	<p>Coverage assumes enrollment in Medicare Part B;                  Plan pays remainder of charges approved by not paid by Medicare Part B and member has \$0 responsibility</p>
<p><b>Physical Therapy Services</b>                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>
<p><b>Short-Term Rehabilitation</b>                  Covered by Medicare Part B                  Includes:                  - Cardiac Rehab                  - Speech Therapy                  - Occupational Therapy                  - Pulmonary Rehab                  - Cognitive Therapy                  Chiropractic Therapy (includes Chiropractors)</p>	<p>Remainder 20% of Medicare approved amount                  Limited to \$1,940 per calendar year for Physical Therapy (PT) and Speech Therapy Language Pathology (SLP) services combined;                  Limited to \$1,940 per calendar year for Occupational Therapy services</p>

Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 Medicare Retiree High HMO Plan Without Rx

Proposed Plan/Deviations

<p><b>Home Health Care</b>                  When covered by Medicare                  When not covered by Medicare</p>	<p>No Charge                  Plan will pay up to \$40 per visit limited to \$1,600 per calendar year</p>	
<p><b>Private Duty Nursing</b>                  Covered by Medicare Part B                  (While Inpatient Hospital or Other Health Care Facility Only)</p>	<p>80% of the Reasonable &amp; Customary charges after \$147 calendar year deductible</p>	
<p><b>Hospice Care</b>                  Inpatient Services                  Outpatient Services (same coinsurance level as Home Health Care)</p>	<p>Plan pays 100% of amount approved but not paid by Medicare; when Medicare certification and election requirements are met.</p>	
<p><b>Skilled Nursing Facilities</b>                  Days 1-20: Covered by Medicare Part A                  Days 21-100: Covered all but \$157.50 per day</p>	<p>Days 1-20: Not Covered                  Days 21-100: 100% up to \$157.50 per day                  Days 101 &amp; Beyond: Not Covered</p>	
<p><b>Durable Medical Equipment and External Prosthesis</b>                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	
<p><b>Other</b></p>		
<p>Infertility - Office Visit for Diagnosis                  Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount</p>	
<p>Bariatric Surgery</p>	<p>Not Covered</p>	
<p>Acupuncture</p>	<p>Not Covered</p>	
<p>Glasses                  Covered by Medicare Part B</p>	<p>Not Covered</p>	
<p>Dental Check-Up</p>	<p>Not Covered</p>	
<p>Eye Exam</p>	<p>Not Covered</p>	
<p>Hearing Aids</p>	<p>Not Covered</p>	

Miami-Dade County  
 Medicare Retiree Low HMO Plan With Rx

		Proposed Plan/Deviations
Calendar Year Deductible		\$147 for Private Duty Nursing/Per Individual \$250 for Foreign Travel Emergency Care/Per Individual
Out-Of-Pocket Maximums: Individual / Dependent Coverage		N/A
Lifetime Maximum Benefit		Unlimited
Medicare Part B Deductible: \$147 Per Calendar Year		Not Covered
Choice of Hospitals		Unlimited
Emergency Services/Urgen Care Services		Member Responsibility
Emergency and Urgent Care Services Covered by Medicare Part B		Not Covered
Ambulance Covered by Medicare Part B		Not Covered
Prescription Drugs		
Participating Pharmacy: 30-day supply at participating pharmacy - Retail		80% after \$200 calendar year deductible
Mail Order (MO) - 90-day supply at participating pharmacy (Includes contraceptives)		Generic - \$10 copay Preferred Brand - \$20 copay Non-Preferred Brand - \$30 copay
Specialty Drugs: 30-day supply at participating specialty pharmacy		\$100 copay per prescription
Inpatient Hospital Services		Member Responsibility

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**Miami-Dade County  
Medicare Retiree Low HMO Plan With Rx**

**Proposed Plan/Deviations**

<p>Inpatient Hospital Facility Services (Semi-Private Room and Board) Covered by Medicare Part A. Medicare covers: Days 1-60: All but \$1,260 Days 61-90: All but \$315 per day Days 91-150: All but \$630 per day *Days 91-150 are the 60 Lifetime Reserve Days. Medicare will cease until a new Benefit Period begins. A new Benefit eriod begins after you have been out of the hospital or facility for at least 60 days. In a new Benefit Period, all Medicare Part A will renew except for the Lifetime Reserve Days.</p>	<p>100% up to \$1,260 100% up to \$315 per day 100% up to \$630 per day *365 additional lifetime days after Medicare Lifetime Reserve Days are exhausted Covered at 100% of Medicare eligible expense Must be medically necessary Limiting semi-private room (unless medically necessary) and board amount</p>	
<p>X-Rays Covered by Medicare Part B</p>	<p>Not Covered</p>	
<p><b>Office Visits</b></p>	<p><b>Member Responsibility</b></p>	<p><b>Member Responsibility</b></p>
<p>Physician's Office Visit/Illness Covered by Medicare Part B</p>	<p>Not Covered</p>	
<p>Specialist Office Visits Covered by Medicare Part B</p>	<p>Not Covered</p>	
<p>Allergy Injections Covered by Medicare Part B</p>	<p>Not Covered</p>	

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**Miami-Dade County  
Medicare Retiree Low HMO Plan With Rx**

**Proposed Plan/Deviations**

<p>Maternity Care Services - Covered by Medicare Part B Initial Visit to confirm pregnancy/All subsequent prenatal and postnatal visits  Delivery and All Inpatient - Covered by Medicare Part A (Inpatient Hospital or Birthing Center)</p>	<p>Remainder 20% of Medicare approved amount  Days 1 to 60: 100% up to \$1,250 Days 61 to 90: 100% up to \$315 per day Days 91 - 150: 100% up to \$630 per day</p>	
<p>Complex Radiological Imaging (CT, MRI, MRA, PET) Covered by Medicare Part B</p>	<p>Not Covered</p>	
<p><b>Outpatient Services</b></p>		
<p>Hospital Outpatient/Physician Covered by Medicare Part B</p>	<p>Remainder 20% of Medicare approved amount for these services only: Physician hospital visits (Inpatient/Outpatient) Surgical services (Inpatient/Outpatient) Anesthesia services (Inpatient/Outpatient)</p>	
<p><b>Mental/Nervous Disorders Health Care</b></p>		
<p>Inpatient Covered by Medicare Part A Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1</p>	<p>Plan pays 100% of amount approved but not paid by Medicare; if charges not approved by Medicare, there is no coverage.</p>	
<p>Outpatient Covered by Medicare Part B</p>	<p>Coverage assumes enrollment in Medicare Part B; Plan pays remainder of charges approved by not paid by Medicare Part B and member has \$0 responsibility</p>	
<p><b>Drug and Alcohol Rehabilitation Programs</b></p>		

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Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
 Medicare Retiree Low HMO Plan With Rx

Proposed Plan/Deviations

<p><b>Inpatient</b>                  Covered by Medicare Part A                  Acute detoxification: requires 24-hour nursing; based on a ratio of 1:1                  Acute Inpatient Rehab: requires 24-hour nursing; based on a ratio of 1:1                  Partial: based on a ratio of 2:1                  Residential: based on a ratio of 2:1</p>	<p>Plan pays 100% of amount approved but not paid by Medicare; if charges not approved by Medicare, there is no coverage.</p>	
<p><b>Outpatient</b>                  Covered by Medicare Part B</p>	<p>Coverage assumes enrollment in Medicare Part B; Plan pays remainder of charges approved by not paid by Medicare Part B and member has \$0 responsibility</p>	
<p><b>Home Health Care</b>                  Not covered by Medicare</p>	<p>Not Covered</p>	
<p><b>Private Duty Nursing</b>                  Covered by Medicare Part B                  (While Inpatient Hospital or Other Health Care Facility Only)</p>	<p>80% of the Reasonable &amp; Customary charges after \$147 calendar year deductible. Lifetime maximum \$10,000 combined with blood and blood products.</p>	
<p><b>Skilled Nursing Facilities</b>                  Days 1-20: Covered by Medicare Part A                  Days 21-100: Covered all but \$157.50 per day</p>	<p>Not Covered</p>	
<p><b>Durable Medical Equipment and External Prosthesis</b>                  Covered by Medicare Part B</p>	<p>Not Covered</p>	
<p><b>Other</b>                  Infertility - Office Visit for Diagnosis                  Covered by Medicare Part B</p>	<p>Not Covered</p>	
<p>Bariatric Surgery</p>	<p>Not Covered</p>	
<p>Acupuncture</p>	<p>Not Covered</p>	

Attachment 5 - Plan Designs Worksheet

Miami-Dade County  
Medicare Retiree Low HMO Plan With Rx

Proposed Plan/Deviations	
Glasses Covered by Medicare Part B	Not Covered
Dental Check-Up	Not Covered
Eye Exam	Not Covered
Hearing Aids	Not Covered

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Exhibit 1 - CPT Code Analysis

Sample Physician Fee Schedules

CPT4 Code	Description	Average Negotiated Allowable Fee			R&C
		HMO	POS	PPO	
<b>Global Fees</b>					
11100	Biopsy Skin Lesion	\$	\$	\$	-
17110	Destruct B9 Lesion 1-14	-	-	-	-
20610	Drain/Inject Joint/Bursa	-	-	-	-
31231	Nasal Endoscopy Dx	-	-	-	-
31575	Diagnostic Laryngoscopy	-	-	-	-
43239	Egd Biopsy Single/Multiple	-	-	-	-
45378	Diagnostic Colonoscopy	-	-	-	-
45380	Colonoscopy And Biopsy	-	-	-	-
45385	Lesion Removal Colonoscopy	-	-	-	-
51798	Us Urine Capacity Measure	-	-	-	-
71020	Chest X-Ray 2Vw Frontal&Latl	-	-	-	-
72148	Mri Lumbar Spine W/O Dye	-	-	-	-
73221	Mri Joint Upr Extrem W/O Dye	-	-	-	-
73721	Mri Jnt Of Lwr Extre W/O Dye	-	-	-	-
76536	Us Exam Of Head And Neck	-	-	-	-
76645	Us Exam Breast(S)	-	-	-	-
76700	Us Exam Abdom Complete	-	-	-	-
76705	Echo Exam Of Abdomen	-	-	-	-
76770	Us Exam Abdo Back Wall Comp	-	-	-	-
76775	Us Exam Abdo Back Wall Lim	-	-	-	-
76816	Ob Us Follow-Up Per Fetus	-	-	-	-
76830	Transvaginal Us Non-Ob	-	-	-	-
76856	Us Exam Pelvic Complete	-	-	-	-
77014	Ct Scan For Therapy Guide	-	-	-	-
77056	Mammogram Both Breasts	-	-	-	-
77057	Mammogram Screening	-	-	-	-
77080	Dxa Bone Density Axial	-	-	-	-
77418	Radiation Tx Delivery Imrt	-	-	-	-
78452	Ht Muscle Image Spect Mult	-	-	-	-
87621	Hpv Dna Amp Probe	-	-	-	-
88175	Cytopath C/V Auto Fluid Redo	-	-	-	-
88305	Tissue Exam By Pathologist	-	-	-	-
88312	Special Stains Group 1	-	-	-	-
90460	Im Admin 1St/Only Component	-	-	-	-
90649	Hpv Vaccine 4 Valent Im	-	-	-	-
90670	Pneumococcal Vacc 13 Val Im	-	-	-	-

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Exhibit 1 - CPT Code Analysis

Sample Physician Fee Schedules

CPT4 Code	Description	Average Negotiated Allowable Fee			R&C
		HMO	POS	PPO	
90734	Meningococcal Vaccine Im	-	-	-	-
90834	Psytx Pt&/Family 45 Minutes	-	-	-	-
90837	Psytx Pt&/Family 60 Minutes	-	-	-	-
90935	Hemodialysis One Evaluation	-	-	-	-
90945	Dialysis One Evaluation	-	-	-	-
92004	Eye Exam New Patient	-	-	-	-
92012	Eye Exam Establish Patient	-	-	-	-
92014	Eye Exam&Tx Estab Pt 1/>Vst	-	-	-	-
93000	Electrocardiogram Complete	-	-	-	-
93010	Electrocardiogram Report	-	-	-	-
93015	Cardiovascular Stress Test	-	-	-	-
93306	Tte W/Doppler Complete	-	-	-	-
93880	Extracranial Bilat Study	-	-	-	-
93970	Extremity Study	-	-	-	-
95004	Percut Allergy Skin Tests	-	-	-	-
95024	Incut Allergy Test Drug/Bug	-	-	-	-
95165	Antigen Therapy Services	-	-	-	-
96372	Ther/Proph/Diag Inj Sc/Im	-	-	-	-
96413	Chemo Iv Infusion 1 Hr	-	-	-	-
96420	Chemo Ia Push Technique	-	-	-	-
97001	Pt Evaluation	-	-	-	-
97014	Electric Stimulation Therapy	-	-	-	-
97110	Therapeutic Exercises	-	-	-	-
97112	Neuromuscular Reeducation	-	-	-	-
97140	Manual Therapy 1/> Regions	-	-	-	-
97530	Therapeutic Activities	-	-	-	-
97810	Acupunct W/O Stimul 15 Min	-	-	-	-
97811	Acupunct W/O Stimul Addl 15M	-	-	-	-
97814	Acupunct W/Stimul Addl 15M	-	-	-	-
98940	Chiropract Manj 1-2 Regions	-	-	-	-
98941	Chiropract Manj 3-4 Regions	-	-	-	-
98943	Chiropract Manj Xtrspinal 1/>	-	-	-	-
99202	Office/Outpatient Visit New	-	-	-	-
99203	Office/Outpatient Visit New	-	-	-	-
99204	Office/Outpatient Visit New	-	-	-	-
99205	Office/Outpatient Visit New	-	-	-	-
99212	Office/Outpatient Visit Est	-	-	-	-

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**RFP No. 00196**

**Self-Funded Employee Group Healthcare Program**

**Exhibit 2 – Medical Claims Re-pricing Analysis**

Please go to the following link to access Exhibit 2: \\miamidade\nas1\dpm\DPM-Share\BidSync-Share\RFP-00196

**RFP No. 00196**

**Employee Group Healthcare Program**

**Exhibit 3 – Pharmacy Claims Re-pricing Analysis**

Please go to the following link to access Exhibit 3: \\miamidade\nas1\dpm\DPM-Share\BidSync-Share\RFP-00196



**RFP No. 00196**

**Employee Group Healthcare Program**

**Exhibit 5 – Specialty Prescription Drug List Sample**

Please go to the following link to access Exhibit 5: <\\miamidade\nas1\dpm\DPM-Share\BidSync-Share\RFP-00196>

**RFP No. 00196**

**Employee Group Healthcare Program**

**Exhibit 6 - Top Utilized Physicians/Providers**

Please go to the following link to access Exhibit 6: <\\miamidade\nas1\dpm\DPM-Share\BidSync-Share\RFP-00196>