

Introduction

The City of Grand Island is seeking proposals for a firm to be the administrator for the City's Medical/Rx Health Plan.

The City is not in search of an insurance broker or consultant at this time. Therefore, all proposals submitted should be submitted net of any broker or consultant commissions. The City of Grand Island is under contract with a consultant at this time. Our consulting firm is Gallagher Benefit Services, Inc.

If you are an insurance carrier, or a third party administrator with ability to provide re-insurance proposals as well, you are invited to submit a proposal for these services to the City of Grand Island, Nebraska. The deadline for submission of any proposals will be 4:00 pm local time on June 30th, 2022. Proposals received after this time will be returned unopened to the sender.

NOTE: The City of Grand Island is requesting proposal that EXACTLY matches their current coverage, and also a second set of proposals with different options detailed, each priced separately as the City may elect some or all of the coverage options. RFP details attached.

All questions of items of clarification for the Request for Proposal (RFP) of any ambiguity, inconsistency or errors which a potential vendor may find are to be directed to:

Mike Graham
Gallagher Benefit Services, Inc.
10050 Regency Circle, Suite 300
Omaha, NE 68114

OR

Tami Herald
Benefits & Risk Management Coordinator
100 East First Street
P.O. Box 1968
Grand Island, NE 68802-1968
308-385-5444 ext. 192
308-385-5422
TamiH@grand-island.com

Phone: 402-829-1035

Fax: 402-694-3012

E-mail: mike_graham1@ajg.com

All interpretations, corrections and changes made to the specifications will be made in writing. Oral interpretations or changes made to the specifications in any other manner will not be binding on the City of Grand Island, and any vendor shall not rely on any oral interpretations or changes.

All information about The City of Grand Island, Nebraska, its Medical/Rx Health Plan, this Request for Proposal, and any other information is fully confidential and shall not be released without the City of Grand Island's written consent.

Delivery of Proposals

Please submit your complete proposal via one of the following methods:

1. The Original and three (3) copies and one electronic copy (readable Flash Drive) to:

City Clerk
Grand Island City Hall
P.O. Box 1968
100 East First Street
Grand Island, NE 68802-1968

OR

2. Submit your proposal online via QuestCDN. Additional information can be found here:
<https://www.grand-island.com/government/city-clerk/bid-document-information>

PLEASE NOTE: All addendums to this RFP document will **ONLY** be provided via the QuestCDN website.

Any exhibits, documentation, and collateral materials must be assembled and submitted with the proposal in a single package.

The proposal must be signed by a person authorized to negotiate a contract of the scope, terms, specifications, and pricing outlined in the proposal. No oral quotations or modifications of the bound proposal will be accepted. Pricing must be guaranteed for 60 days. Any modification to the original proposal must be made in writing. All costs and expenses of preparing and submitting a proposal are the responsibility of the firm submitting the proposal.

The City of Grand Island and its consultant will endeavor to protect the confidentiality of proprietary information as such information is identified as proprietary. The City of Grand Island will not share your information with any entities that compete with your firm. Any other specific restrictions for your proposal must be clearly stated in your material.

The City of Grand Island reserves the right to accept or reject any and all proposals submitted or to modify any requirements or assumptions stated in the RFP before signing a final agreement with any firm. No firm may make a claim against The City of Grand Island, NE for exercise of any of these rights. The City of Grand Island will choose the firm whose proposal is most advantageous to the City, not necessarily the lowest bidder.

All proposals must be presented with plan and fee structures and insurance costs that are firm for the City of Grand Island's renewal date of 10-1-2022.

Selections of Firm (Vendor)

The City of Grand Island, NE (The City) will evaluate proposals based on:

- ❖ Ability to meet key service criteria described in this RFP (attached)
- ❖ Quality of service provided to plan participants
- ❖ Ability to provide claims management systems and processes
- ❖ Quality of service provided to Administrative staff of The City of Grand Island
- ❖ Ability to adapt the plan over time to meet ongoing City needs
- ❖ Quality of employee education and materials
- ❖ Client references
- ❖ Fees and insurance costs

Upon review of the submitted written proposals, multiple firms may be chosen for on-site interviews. These firms will be notified **after June 30, 2022**. City of Grand Island will notify all firms of the results in writing. The firms selected for on-site interviews at The City of Grand Island are currently scheduled to be the week of **July 11, 2022**, with the actual date determined later. All interviews will be held the same day.

The City anticipates implementing any plan and/or administrative changes as of **October 1st, 2022**.

GRATUITIES AND KICKBACKS

City Code states that it is unethical for any person to offer, give or agree to give any City employee or former City employee, or for any City employee or former City employee to solicit, demand, accept, or agree to accept from another person, a gratuity or an offer of employment in connection with any decision, approval, disapproval, recommendation, or preparation of any part of a program requirement or a purchase request, influencing the content of any specification or procurement standard, rendering of advice, investigation, auditing, or in any other advisory capacity in any proceeding or application, request for ruling, determination, claim or controversy, or other particular matter, pertaining to any program requirement or a contract or subcontract, or to any solicitation or proposal therefore. It shall be unethical for any payment, gratuity, or offer of employment to be made by or on behalf of a subcontractor under a contract to the prime contractor or higher tier subcontractor or any person associated therewith, as an inducement for the award of a subcontract or order.

INSURANCE COVERAGE

The proposer shall purchase and maintain at his expense as a minimum insurance coverage of such types and in such amounts as are specified herein to protect proposer and the interest of Owner and others from claims which may arise out of or result from proposer's operations under the Contract Documents, whether such operations be by proposer or by any Subcontractor or anyone directly or indirectly employed by any of them or for whose acts any of them may be legally liable. Failure of proposer to maintain proper insurance coverage shall not relieve him of any contractual responsibility or obligation.

FAIR EMPLOYMENT PRACTICES

Each proposer agrees that they will not discriminate against any employee or applicant for employment because of age, race, color, religious creed, ancestry, handicap, sex or political affiliation.

LB 403

Every public contractor and his, her or its subcontractors who are awarded a contract by the City of Grand Island for the physical performance of services within the State of Nebraska shall register with and use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska.

FISCAL YEARS

The City of Grand Island, Nebraska operates on a fiscal year beginning October 1st and ending on the following September 30th. It is understood and agreed that any portion of this agreement which will be performed in a future fiscal year is contingent upon the City Council adopting budget statements and appropriations sufficient to fund such performance.

TITLE VI

The City of Grand Island, in accordance with Title VI of the Civil Rights Act of 1964, 78 Stat. 252, 42 U.S.C 2000d to 2000d-4 and Title 49, Code of Federal Regulations, Department of Transportation, Subtitle A, Office the Secretary, Part 21, Nondiscrimination in Federally assisted programs of the Department of Transportation issued pursuant to such Act, hereby notified all bidden that it will affirmatively insure that in any contact entered into pursuant to this advertisement, minority business enterprises will be afforded full opportunity to submit bids in response to this invitation and will not be discriminated against on the grounds of race, color, or national origin, sex, age and disability/handicap in consideration for an award.

SECTION 504/ADA NOTICE TO THE PUBLIC

The City of Grand Island does not discriminate on the basis of disability in admission of its programs, services, or activities, in access to them, in treatment of individuals with disabilities, or in any aspect of their operations. The City of Grand Island also does not discriminate on the basis of disability in its hiring or employment practices.

This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. Questions, complaints, or requests for additional information or accommodation regarding the ADA and Section 504 may be forwarded to the designated ADA and Section 504 compliance coordinator.

City Administrator
308-385-5444, extension 140
100 East First Street, Grand Island, NE 68801
Monday through Friday; 8:00 a.m. to 5:00 p.m.

PROPOSAL TERMS AND CONDITIONS

The City will not pay any costs incurred by the firm in preparing or submitting the proposal. The City reserves the right to modify or cancel, in part or in its entirety, this RFP. The City reserves the right to reject any or all proposals, to waive defects or informalities, and to offer to contract with any firm in response to any RFP. This RFP does not constitute any form of offer to contract.

City of Grand Island
Request for Proposal
Medical/Rx Health Plan
Third Party Administrative Services
May 2022

Background on Health Insurance Plan

The City of Grand Island has sponsored a Group Health Plan for more than 25 years. The City of Grand Island currently utilizes a self-funded plan with a Specific and Aggregate Stop Loss coverage for the Health Plan. The current administrator is UMR with SunLife as the reinsurance carrier. The Health Plan is priced on a three (3) tier structure, with the tiers being Employee, 2/4 (Employee + Children or Employee + Spouse), and Family coverage. The City of Grand has 500 employees enrolled on the health plan.

The current plan year is October 1st through September 30th of each following year for the Health Insurance. All plan features such as deductibles, Co-insurance, preventive care, and plan maximums are managed on a calendar year structure.

The City of Grand Island currently utilizes UMR for this plan.

Plan level administration, payroll items, employee changes, etc. are handled by the staff of The City of Grand Island Human Resources department. The City of Grand Island does not want the claim fiduciary responsibility for appeals and expects the firm selected to fulfill this role.

It has been the practice of The City to enter the RFP process every 3-5 years to perform their due diligence and to make sure the current plan is offering competitive options and pricing, with efficient processing and service. The most recent reviews were done in 2012, 2015 and 2019.

The terms of the RFP are included in the attached spreadsheet.

The City of Grand Island is seeking quotes for Administrative Services and Plan Management on Medical and Rx claims for the year beginning October 1, 2022 thru September 30, 2023 based on our current Medical benefit structure.

Attached is the RFP content requested from each vendor participating in the RFP process for the City of Grand Island.

Request for Proposal (RFP)

Account	City of Grand Island
Applicable From	1/1/2023
Applicable To	1/1/2026
RFP Due Date	
Client's Address and Industry	
Address	100 East First Street
City, State, Zip	Grand Island, NE 68802-1968
Description of Industry	City
Line of Coverage(s)	
	Medical Administration

**Please confirm that you accept the terms in this RFP by signing below.
Once signed, please include this page with your quote submission.**

Vendor/Representative Name mm/dd/yyyy

Vendor / Representative Date

Carrier/Vendor Name

Carrier/Vendor

Medical TPA RFP - General Information

Contract	Services	Details
Administrator	UXM	Included
Medical Record Vision Administration	Included	Included
Network Access Fees	Included	Included
Cost Reductions and Savings Incentive Program	25% of savings with a \$50,000 to \$100,000 cap per plan	25% of savings with a \$10,000 savings cap per plan
Standard Reporting	Included	Included
Custom Ad Hoc Reporting	\$100/hour after 2 hours	\$100/hour after 2 hours
BASE DISEASE MANAGEMENT		
Diabetes	Not Included	Not Included
Congestive Heart Failure	Not Included	Not Included
Coronary Artery Disease	Not Included	Not Included
Chronic Obstructive Pulmonary Disorder	Not Included	Not Included
Asthma	Not Included	Not Included
Additional Diseases Covered	Not Included	Not Included
FEDERARY SERVICES	Included	Included
PRM	Optional	Optional
Administrative Fees are reduced by the rebate credit	Administrative Fees are reduced by the rebate credit	
PERFORMANCE GOALS	Included	Included
DEDICATED ACCOUNT MANAGEMENT TEAM	Included	Included
ONLINE SERVICES AND CAPABILITIES	Included	Included
CASE MANAGEMENT	Included	Included
AUTO-ADJUDICATION	Included	Included
ADDITIONAL CARE FACILITATION:		
Medical Review	Included	Included
Health Awareness Education	Included	Included
Costly Programs	Included	Included
Prescription Drug Remission Promotion	Included	Included
Point of Sale Pharmacy	Included	Included
Health Risk Assessment	Included	Included
STORAGE FEE	\$200	\$200
ADDITIONAL SERVICES		

Medical TPA RFP - Service Questionnaires

A. PERFORMANCE GUARANTEES	<p>1.) Will you agree to offer a Performance Guarantee with financial penalties?</p> <ul style="list-style-type: none"> ! If yes, include your proposed performance guarantee in your proposal. ! Indicate the total amount you are willing to put at risk.
B. IMPLEMENTATION, ENROLLMENT, ELIGIBILITY AND MAINTENANCE QUESTIONS	<p>2.) What is the normal lead-time required to implement a group?</p> <p>3.) What mediums do you accept for plan enrollment?</p> <p>4.) Do you offer online eligibility maintenance for all clients?</p> <ul style="list-style-type: none"> ! If so, is there a charge? ! Is there a charge for hard copy maintenance? <p>5.) Are you able to provide a formal and detailed implementation plan.</p>
C. CUSTOMER SERVICES/SATISFACTION QUESTIONS	<p>6.) Do you complete customer service surveys?</p> <ul style="list-style-type: none"> ! How frequently do you conduct satisfaction surveys? ! What percentage of participants is surveyed? ! What is your performance standard for patient satisfaction survey results? <p>7.) What are your customer service hours?</p> <p>8.) How many Customer Service Representatives are available?</p> <p>9.) What is your average speed to answer customer service calls?</p> <p>10.) Will there be a dedicated customer service team?</p> <p>11.) Will there be a dedicated claims processing team or will they be in a pool with all other clients?</p>

Medical TPA RFP - Service Questionnaires

D. TECHNOLOGY QUESTIONS

12.) Which of the following tasks can members and plan sponsor representatives

perform online? (Members, Plan Sponsors or Both)

- Enrollment (New Hires and Open Enrollment)
- Changes in Status
- Billing (Plan Administrators only)
- Claim inquiry
- Provider search
- Access provider directories
- Physician/provider cost and quality comparison
- ID card request
- Electronic EOB
- Terminations

13.) Describe any additional services offered to support client's HR/Benefits Team.

14.) Is there an additional cost for online services?

- If yes, please describe.

15.) What percentage of claims is auto-adjudicated through your system?

16.) Do you have any cost transparency tools for members?

- If yes, please describe.

E. REPORTING QUESTIONS

17.) Are you able to provide data that benchmarks experience against the following:

- Your book of business
- National norms
- Similar sized groups

18.) Provide a list of all standard and optional reports available and associated costs (if any).

19.) Are you able to create ad-hoc reporting?

- If yes, please note any additional charges.

20.) What is the lag time on reports listed above?

21.) Does the broker have the ability to access your database in real time for purposes of:

- Tracking plan experience
- Utilization patterns
- Other available plan information

22.) How is this ability provided?

23.) Is there an additional charge to the client?

- If yes, what is the charge?

Prepared by:



Gallagher Benefit Services, Inc.

Medical TPA RFP - Service Questionnaires

F. DISEASE MANAGEMENT PROGRAM

24.) Are the following reports available? If so, is there an additional charge?

- ! Cost savings reports
- ! Utilization reports
- ! Any additional reports (if applicable)

25.) Do you proactively contact potential Disease Management candidates without waiting for them to contact you?

- ! If yes, please note the different communication methods used.

26.) What DM interventions does your organization propose to provide?

27.) Are any Centers of Excellence required by your plans?

28.) What is the frequency of your program reports?

29.) Has your DM program been audited by any outside firm for effectiveness?

- ! If yes, by whom and what date?

30.) What diseases are covered in your base disease management plan?

31.) Are there additional diseases that can be covered?

- ! If yes, what is the charge?

G. RETAIL PHARMACY NETWORK

32.) Identify your PBM.

- !

33.) Are networks of varying size available? Please clearly describe differences in participating pharmacies, differences in discount arrangements, and estimated overall impact on drug spending.

34.) How do you handle specialty drugs?

- ! Are there any prior authorization requirements?
- ! If yes, please describe.

35.) Describe your process for Rx protocol of dosage and refill frequency.

36.) Outline/explain any and all dosage or quantity limitations.

37.) Are there any specific situations where you would override or deny a physician's prescription?

- ! If yes, please describe.

Prepared by:



Gallagher Benefit Services, Inc.

Medical TPA RFP - Service Questionnaires

H. PHARMACY FORMULARY & REBATES

- 38.) How is your formulary established?
- 39.) Do all drug manufacturers whose products are included in your formulary provide your network with rebates?
 If so, how are the rebates shared with the plan sponsor?
 If so, are the rebate dollars paid to the plan sponsor or are credits given prospectively?
 Do you provide minimum rebate guarantees?
- 40.) Will you agree to remit or credit back to premium 100% of manufacturers' rebates and incentives of any kind to the employer?
 If not, what percentage and how often?
- 41.) Does the formulary rebate program apply to the mail order program?
- 42.) Do you guarantee that ingredient cost charges made by network pharmacies will be based on the lesser of the discount offered, actual retail paid, MAC price or your actual acquisition costs?
 If not, please explain.
- 43.) Does the PBM receive rebates or other forms of reimbursement from the manufacturers that is not disclosed or shared with the client?
- 44.) Do you have a specialty drug tier plan provision (i.e., 4th tier)?
- 45.) Are specialty drugs available through mail order?
- 46.) Please outline the categories of medications considered "specialty drugs."

I. MAIL ORDER PRESCRIPTION DRUG PROGRAM

- 47.) Do you have your own mail order prescription drug program?
 If so, is it fully integrated with your retail network?
 Where is your mail order pharmacy located?
- 48.) Do you subcontract with an outside mail order vendor?
 If so, which mail order vendor do you use?
- 49.) Is there an internet pharmacy available through your PBM?
 If so, please describe.
 Please confirm that members can order prescriptions online.

J. PHARMACY CONTRACTING

- 50.) Do you maintain the same pricing contracts for all network pharmacies?
 If not, please explain.

Prepared by:



Gallagher Benefit Services, Inc.

Medical TPA RFP - Service Questionnaires

K. PRESCRIPTION DRUG ELIGIBILITY/MAINTENANCE SERVICES

51.) Is there an additional/separate ID card required for prescription drug coverage?
 | If so, please describe.

52.) Do you charge a fee for card preparation?

L. PRESCRIPTION DRUG REPORTING

53.) Describe the claim and utilization reports that will be made available as part of your quoted fee. Provide samples of all.

M. UTILIZATION MANAGEMENT

54.) From what location(s) are services provided?

55.) Does your UM program have an accreditation separate from your provider network?

56.) Do you have a standard pre-certification requirement for any of the following?

- | Hospitalizations
- | Outpatient Surgery
- | Specified Diagnostic Procedures
- | Durable Medical Equipment
- | Corrective Appliances /Prosthetics
- | Skilled Nursing Facility
- | Home Health Care
- | Musculoskeletal Services (e.g., chiropractic)
- | Medical Services (e.g., physical therap)
- | Mental Health / Substance Abuse
- | Other.

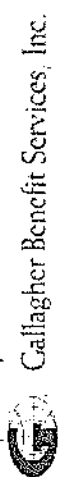
57.) Does your firm perform concurrent review services?

58.) Do you subcontract catastrophic case management services?

- | If so, identify vendor.

59.) During case management, does your staff negotiate fee reductions with providers and vendors?

Prepared by:



Gallagher Benefit Services, Inc.

Medical TPA RFP - Service Questionnaires

N. CLAIMS ADMINISTRATION

- 60.) The claims administrator agrees that the claims and accompanying eligibility data produced in connection with all the claim payment activities on behalf of the client is and will be the property of the client. And, that the client retains the right to request the full and complete data in electronic format with proper notice and at no additional cost.
- 61.) For services covered but not eligible for reimbursement, confirm that available network discounts are applied to any portion of the claim paid by the member.
- 62.) Confirm that you are HIPAA Privacy and Security compliant.
- 63.) Confirm that you are PPACA compliant, particularly as it relates to Claim Appeal requirements.
- 64.) Do you anticipate any major claim / eligibility / reporting system changes or upgrades planned in the next 12 to 24 months?
- 65.) Can your system accept electronic claims submissions?
| What percentage of claims have been submitted electronically?
- 66.) What was the average turnaround time for paid claims?
- 67.) What is the standard percentile used as a basis to determine UCR?
| How often is UCR updated?
| Who administers your UCR?
- 68.) Confirm that if you fail to meet timely payment requirements for in-network providers, neither patients nor the Plan will be liable.
- 69.) Confirm that your system integrates prescription drug data for case management and Disease Management.
| Should the client elect to carve out the prescription coverage to an outside PBM, do you assess any fees to collect and integrate the prescription data for case management and disease management?
- 70.) Should the client elect to carve out Stop Loss, do you assess any fees to transmit medical and/or prescription drug claim data to those entities?
- 71.) Should the client elect to carve out Stop Loss, do you have any limitations regarding the level (dollar level or percentage of attachment point), at which you are willing to report potential claims to the Stop Loss carrier?
- 72.) Are there any Stop Loss vendors that your firm will not agree to work with?
- 73.) What is the runoff claims processing fee?

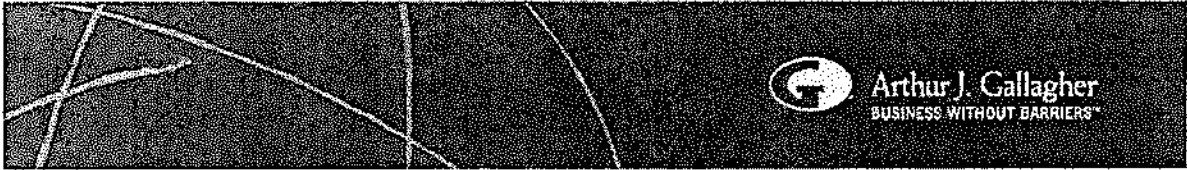
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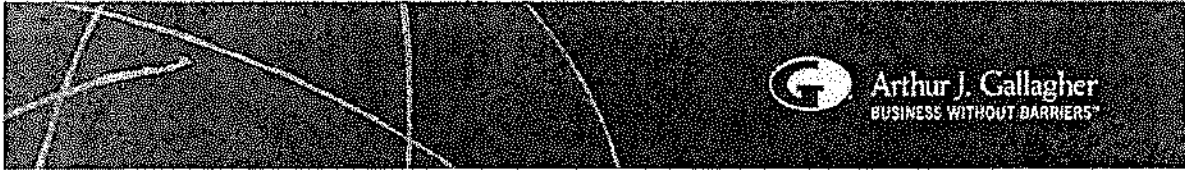
Medical TPA RFP - Service Questionnaires

- 74.) After the runout period, how will you handle the following:
- ! Claims in house, but not processed?
 - ! Claims submitted after the runout period?
- 75.) Confirm that you will provide final reports consistent with your standard reporting to the plan.
- 76.) Are you quoting a leased provider network, or do you own your network?
- 77.) Do you perform subrogation internally? Or, do you use an outside vendor?
- 78.) Are network discount reports provided?
- ! If so, what is the frequency of reports?
- 79.) How do you document fraud abuse and savings?
- 80.) Do you provide electronic EOB's
- ! If so, will there be a discount to do so?
- 81.) Do you have any narrow network options available?
- ! If so, please include cost and network details.
- 82.) Do you have any ACO or Medical Home options?
- ! If so, please describe.
- 83.) Do any of your networks pay providers for performance-based care, not fee for service?
- ! If so, please explain.

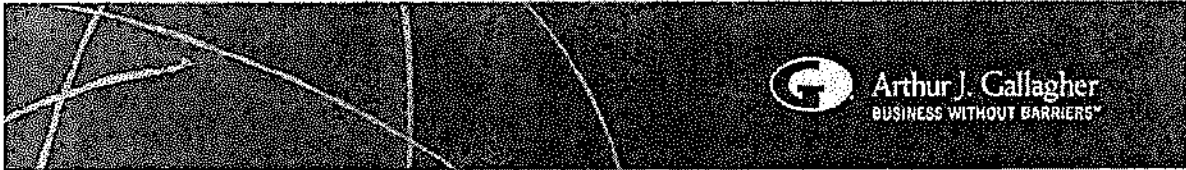


Request for Proposal - Medical and Prescription Drug Benefits

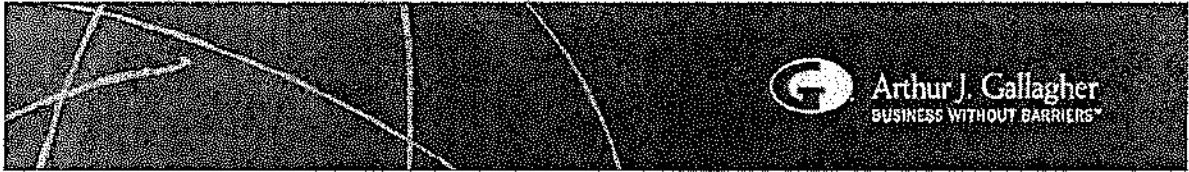
PLAN CONFIRMATIONS	VENDOR RESPONSE
Do you place any limits on liability for error in your contract? If yes, are these limits per occurrence? Do you agree to pay any excise taxes that may be imposed under the Code when the excise tax is applicable due to your organization's error?	
Confirm you will offer a wellness/implementation/transition credit. Please identify what amount of credit you are offering.	
For programs that are outlined/discussed as part of your RFP response, confirm the associated cost is also outlined for those programs.	
Outline any programs offered with the medical coverage (i.e. pregnancy program, wellness, disease management).	
MEDICAL NETWORK ACCESS ANALYSIS	MEDICAL NETWORK ACCESS ANALYSIS
Using the census provided, conduct a geo-access analysis and provide your results in excel format with the following assumptions: Urban, Suburban, Rural Primary Care Physicians (PCPs)*: 2 within 10 miles Pediatricians: 2 within 10 miles OB-GYN: 2 within 10 miles Specialists: 2 within 20 miles Labs: 2 within 20 miles Hospitals: 1 within 20 miles NOTE: For PCPs, please have separate geo access results for (1) PCPs, (2) Pediatricians and (3) OB-GYNs. Also make sure to include a roll-up geo access for ALL PCP types. <i>*PCPs include: (1) Internists, (2) Family Practitioners and (3) Generalists</i> <i>Results need to be in terms of driving distance and not "how the crow flies"</i>	Please confirm c excel
MEDICAL DISRUPTION ANALYSIS	MEDICAL DISRUPTION ANALYSIS
Using the attachment disruption file, provide your results in excel. Emergency Room and Anesthesiologists that are not specifically contracted should be indicated as an out of network provider. Any "Shared Savings" or "National Advantage Plan" providers/relationships should be indicated as out-of-network in your results.	
ADMINISTRATION - SELF FUNDED	ADMINISTRATION - SELF FUNDED
The effective date of coverage is acknowledged and accepted.	<input type="checkbox"/> Agree
Administrative fees must be guaranteed for a minimum of three (3) years from the effective date with the option to renew for an additional two years.	<input type="checkbox"/> Agree
All fees / premiums are quoted NET of commissions; no commissions or fees are to be paid to any entity.	<input type="checkbox"/> Agree
Preliminary renewal rates must be submitted 180 days prior to contract expiration.	<input type="checkbox"/> Agree
You completed the data and network analysis sections, in their entirety, in the format requested.	<input type="checkbox"/> Agree



The vendor will be responsible for producing the Summary Plan Description (SPD) and Summary of Benefits & Coverage (SBC). The City reserves the right to review / revise the SPD and SBC prior to final printing.	<input type="checkbox"/> Agree
Vendor agrees to provide an SBC draft 90 days prior to the effective date and an SPD draft 60 days prior to the effective date.	<input type="checkbox"/> Agree
Vendor agrees to provide all communication materials in electronic (pdf) format.	<input type="checkbox"/> Agree
Vendor agrees to provide detailed plan descriptions no later than 90 days prior to the effective date, to include with the annual enrollment materials.	<input type="checkbox"/> Agree
Vendor agrees to provide all standard reports to the City and their consultant.	<input type="checkbox"/> Agree
Claims experience must be provided at least monthly, including each renewal.	<input type="checkbox"/> Agree
You are in compliance with all HIPAA Privacy, Electronic Data Interface (EDI) and Security Regulations and will use up-to-date HIPAA accepted file formats.	<input type="checkbox"/> Agree
You have reviewed and accept the Plan's eligibility provisions.	<input type="checkbox"/> Agree
Your contract must require no more than a 60-day notice of termination. Your contract cannot prohibit the group from terminating coverage at any time. There must be no penalties for late notification or for termination off anniversary.	<input type="checkbox"/> Agree
If the City utilizes your PBM for pharmacy benefits, the PBM contract must require no more than a 60-day notice of termination and cannot prohibit the group from terminating coverage at any time. There are no penalties for late notification or for termination off anniversary.	<input type="checkbox"/> Agree
Vendor agrees to comply with the Performance Guarantees, and penalties for non-compliance, as provided in this RFP.	<input checked="" type="checkbox"/> Agree
Vendor has specifically listed all deviations from the RFP and coverage requirements in Section XII. NOTE: Deviations MUST be listed; vendors cannot simply make "general" references to the proposal.	<input type="checkbox"/> Agree
If the pharmacy benefit is carved-out, vendor agrees to take feeds (weekly or daily) from the pharmacy vendor and will mine/integrate the data into the medical management program.	<input type="checkbox"/> Agree
Vendor agrees to provide a dedicated reporting contact for the City and GBS. This person would be responsible for running ad hoc reports at the City and/or its Consultant's discretion, at no additional cost to the City.	<input type="checkbox"/> Agree
Vendor agrees to allow the City to interview and select the account management team of its choice within your organization.	<input type="checkbox"/> Agree
Your organization has online capabilities in the following areas:	<input type="checkbox"/> Agree
- <u>Provider selection</u> – tools that will help members select reputable and effective providers	<input type="checkbox"/> Agree
- <u>Quality comparison</u> – tools that will help members compare quality outcomes of providers and facilities	<input type="checkbox"/> Agree
- <u>Price comparison</u> – tools that will allow members to compare the price for services of various hospitals, providers, lab and x-ray facilities, etc.	<input type="checkbox"/> Agree
- <u>Wellness information and tools</u> (i.e. BMI calculator, target heart rate calculator)	<input type="checkbox"/> Agree



What is the fee for you to maintain fiduciary responsibility, and what level of appeals does this include? What do you charge for second-level appeals fiduciary responsibility?	
You must permit the employer to have access to all files on request (e.g., a claims audit).	<input type="checkbox"/> Agree
Run-out claims will be paid by the existing carrier. Your pricing should assume no run-in claim payments.	<input type="checkbox"/> Agree
A. Firm / Organization Questions	
Provide a description of your organization, to include, at a minimum: parent company and location; quoting organization and location, if different; and subcontractors/partners, if any.	
For each organization noted, provide:	
A. Date formed	
B. Ratings of company(s):	
A.M. Best	
Moody's	
Standard & Poor's	
C. Number of employees	
D. Have you recently been acquired or been involved with any merger/acquisition? If yes, describe.	
Who will be your primary liaison with the client?	<input type="checkbox"/> Agree
Identify any other members of the client management team, along with their roles. Provide a resume or an outline of the team members' experience and qualifications.	
Where will they be based? How many other clients will they have?	
Provide a detailed implementation plan, including action items and due dates. Include support for implementation and open enrollment.	
Will you agree to comply with the proposed medical plan Performance Guarantees (as outlined in the Performance Guarantees Section of this RFP)?	<input type="checkbox"/> Agree
If you are unable to comply with the proposed guarantees, provide your alternate proposal.	
Please provide three (3) current client references of similar size to the City:	
A. Client Name	
B. Contact	
C. Address	
D. Telephone number	
E. Approximate number of employees covered by each contract	
Please provide one (1) former client reference of similar size, who may be contacted:	
A. Client Name	
B. Contact	
C. Address	
D. Telephone number	
A. Approximate number of employees covered by each contract	
B. Reason for termination (for former client)	
B. Implementation, Enrollment, Eligibility and Maintenance Questions	
What is the normal lead-time required to implement a group?	



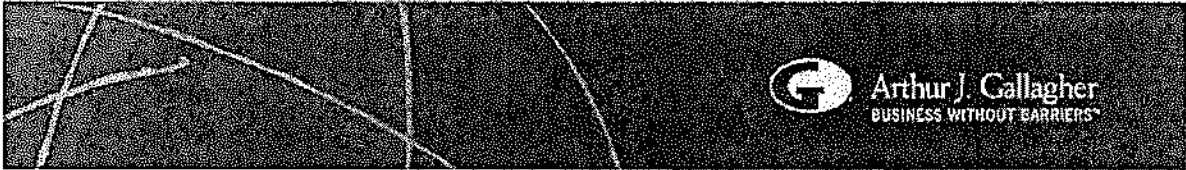
Do you require a deposit or imprest claims?	
If so, how much do you require?	
Describe the options available to the City for submitting eligibility data.	
What mediums do you accept for plan enrollment?	
Do you offer online eligibility maintenance for all clients?	
If so, is there a charge?	
Is there a charge for hard copy maintenance?	
How often is membership updated?	
Can you maintain membership by employee and dependent?	
Explain your billing procedures.	
How frequently are clients billed?	
What charges do the billings encompass?	
Can a plan sponsor be issued separate billings for employee subdivisions (e.g., locations, divisions, union/non-union groups, etc.)?	

C. General Administration Questions

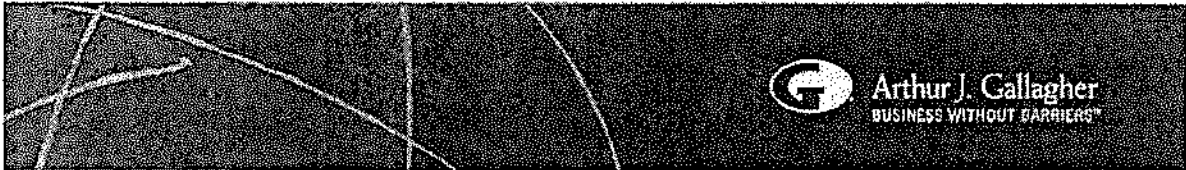
If you are awarded this business, how soon after the notification of the award would you be able to have a draft of the following:	
Benefit Booklet/SPD	
Administrative Agreement(s)	
ID Cards	
With respect to ID cards:	
Do you charge a fee for card preparation? If so, what is this fee?	
Is there a charge for replacement cards? If so, what is the charge?	
Can you put the plan sponsor name and logo on the ID cards?	
Is there an additional charge for this?	
Can you do a combination medical / Rx card (if the PBM is carved-out?) If this is only available with your preferred PBMs, please indicate your preferred PBMs.	
Is there an additional charge for this?	
Will you agree to submit to independent audits at no expense to the client?	
When are fees due under your policy?	
What is the grace period?	
If fees are paid after the grace period, is a penalty and/or interest charge assessed?	
If yes, explain in detail.	
Are there any options available with respect to the grace period?	
If so, explain the option(s) and any charge that is made for them.	

D. HIPAA Questions

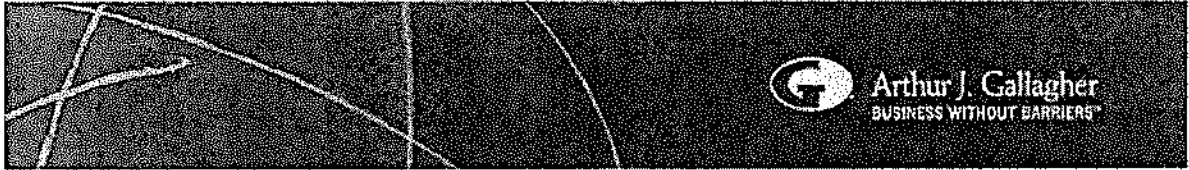
Have you addressed HIPAA in your contracts with clients?	
Indicate if your claims system presently can auto-adjudicate claims electronically, including the origination of electronic payments and credits.	
Include the name and owner of any leased systems or clearinghouses used.	



Do you provide a separate Business Associate Agreement (BAA)? Or is this language included in your contract?	
Does your system support on-line, real-time eligibility inquiries?	
Does your system support on-line, real-time claim status inquiries?	
E. Customer Service / Satisfaction Questions	
Is the member services line available 24/7/365? If not, please indicate hours of operation, and if extended hours are available, what is this additional cost?	
Do you utilize a call distribution and tracking system to monitor and measure customer service performance and statistics?	
Can you track the items outlined below:	
Number of calls received?	
Average speed of answer?	
Call abandonment rates?	
Length of call?	
Others?	
Describe internal performance standards for the customer service unit.	
F. Technology Questions	
Describe the capabilities your website has for the following items:	
<u>Provider selection</u> – tools that will help members select reputable and effective providers	
<u>Quality comparison</u> – tools that will help members compare quality outcomes of providers and facilities	
<u>Price comparison</u> – tools that will allow members to compare the price for services of various hospitals, providers, lab and x-ray facilities, etc.	
<u>Wellness information and tools</u> (i.e. BMI calculator, target heart rate calculator)	
Describe your internal and/or external data-warehousing capabilities.	
Which of the following tasks can members and plan sponsor representatives perform ONLINE?	
	Members
Enrollment (New Hires and Open Enrollment)	<input type="checkbox"/>
Changes in Status	<input type="checkbox"/>
Billing (Plan Administrators only)	<input type="checkbox"/>
Claim inquiry	<input type="checkbox"/>
Provider search	<input type="checkbox"/>
ID card request	<input type="checkbox"/>
Electronic EOB	<input type="checkbox"/>
Terminations	<input type="checkbox"/>
Access provider directories	<input type="checkbox"/>
Reinstatements	<input type="checkbox"/>
Health Risk Assessments	<input type="checkbox"/>
Other	
Is there an additional cost for online services?	
If yes, describe.	
Are provider directories available online?	
G. Reporting Questions	



Are special or ad hoc reports available to the client?	
Are there any additional costs associated with any of these reports?	
If there are additional fees, are the fees generated on a fixed cost per report or billed on an hourly basis?	
Does the client have the ability to access your database in real time for purposes of:	
Adds / deletes	<input type="checkbox"/> Yes
Tracking plan experience	<input type="checkbox"/> Yes
Utilization patterns	<input type="checkbox"/> Yes
Other available plan information	<input type="checkbox"/> Yes
How is this ability provided?	
Is there an additional charge to the client?	
Are you willing to provide a raw claims file to GBS and/or a third party data warehousing vendor at least monthly at no extra charge? If not, what is this cost?	
Do you maintain separate bank accounts for each client?	<input type="checkbox"/> Yes
Do you maintain a record for all checks issued, but not cashed?	<input type="checkbox"/> Yes
How often will you provide this record to the client (monthly, quarterly, annually)?	
Who is responsible for follow-up of uncashed checks?	
Who is responsible for reconciling the bank account?	
What claims adjudication system do you use? (If proprietary, describe the staffing and client response capabilities of your IT staff.)	
Is your system leased/owned?	
When was the system last updated?	
Confirm in writing your ability to adjudicate the existing and alternative benefit plan(s).	
Which provisions would require manual intervention?	
The City reserves the right to carve out PBM and Stop Loss services. Do you agree to this requirement?	<input type="checkbox"/> Yes
Do you charge a stop loss interface fee in a carve out situation? If so, specify amount.	<input type="checkbox"/> Yes
Does the stop loss interface fee include the spec file being sent to the stop loss vendor on a monthly basis? If not, what is this fee?	<input type="checkbox"/> Yes
Do you have a claims quality assurance or review process?	
Describe your system edits for identification of fraudulent claims.	
Describe the types of physician and hospital fee discount arrangements your claims system can accommodate.	
What limitations does your system have?	
Identify and comment on any major claim / eligibility / reporting system changes or upgrades planned in the next 12 to 24 months.	
Describe the claims appeal process and associated timeframes.	
Are there any additional fees associated with this process? If so, what is this fee?	
What method does your firm utilize to determine Usual and Customary (HIAA, company profile, network contracted rates, RVS, etc.) for each state where The Company employees reside?	
HIPAA or related database:	
Other	



Medicare Percentage used?	
Can the client select a different level?	<input type="checkbox"/> Yes
If not Percent of Medicare, what is the % of Medicare equivalent?	
How often are U & C allowances revised?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
What was the average turnaround time for paid claims for the last two years?	
2021	
2020	
Indicate the claims accuracy / error rate for the last two years?	
2021	
2020	
Can your system detect unbundling of services?	<input type="checkbox"/> Yes
Can your system detect "code creeping"?	<input type="checkbox"/> Yes
If yes, what action do you take upon discovery?	
Explain in detail your procedures for identification and recovery of third party liability and coordination of benefits claims. For example:	
Do you outsource this service? Can the City retain its own legal counsel to provide this service? Will that impact fees?	
Does your claim system readily identify potential possible subrogation/COB opportunities prior to claim payment?	
Do you pend and pursue or pay and pursue these types of claims?	
Who performs your Medical Reviews	
Are they included in your fees?	
If not, what is the additional fee for this service?	
Audits	
What is the frequency of audits done by your internal staff?	
What is the frequency of audits done by external vendors?	
Who performs the external audits?	
Would you be willing to allocate an allowance for outside audits?	<input type="checkbox"/> Yes
If so, specify dollar allowance.	
In the event of contract termination, how will you process "run-out" claims:	
Service not available	
A predetermined fee per claim processed (specify amount)	
A predetermined percentage of paid claims (specify amount)	
Duration of run-out claims adjudication	
3 months	
6 months	
12 months	
Other	
In the event of contract termination, how will you process the following:	
Claims in house, but not processed?	
Claims submitted prior to termination but not received by your firm until after the termination?	



Claims submitted after the termination?	
Would you agree to process run-out claims to match the timely filing provision(s) of the plan?	<input type="checkbox"/> Yes
Please provide your calculation for the cost of run-out.	

H. Network Questions

How are physicians reimbursed?	Check ALL that apply: <input type="checkbox"/> Salary <input type="checkbox"/> Per Capita <input type="checkbox"/> Discounted <input type="checkbox"/> Other (Describe)
--------------------------------	---

Is there any withhold on their payments?	<input type="checkbox"/> Yes
--	------------------------------

If yes how and when is it to be paid to them?

How are providers reimbursed when the patient is referred outside the managed care network?

For claims incurred out of your network service area, what hospital and physician discounts are available?

If you use proprietary networks, please identify.

How are out of network allowable amounts determined? Please explain methodology and any partnerships or vendors used in the determination of reasonable and customary.

With regard to network directories, please respond to the following items. (NOTE: Do NOT include a provider directory with your proposal.)

Is your directory available on the internet on a website?

How are members, plan sponsors and providers notified of changes?

Do you own your provider network(s), or do you subcontract? If you should subcontract, please identify network.

Describe the following:

Provider selection process

Credentialing process

Recredentialing process

What are the minimum criteria for providers to be selected as a network provider?

Are you willing to add providers specifically requested by the client?

Do participating network providers have a contractual agreement not to "balance bill" the patient?

Does your network include clinician-staffed clinics in a retail setting? (e.g. RediClinic, etc.) Please elaborate.

Do you have tiered network capabilities? Please elaborate and provide suggestions for the City in this area.

Are out of network charges applicable to discounts, percentage of savings arrangements, Medicare plus allowance? Please describe.

How will you assist The Company and employees in emphasizing employee health and promote and encourage healthy behaviors?

How will you promote and encourage high quality care (including use of evidence-based treatment) from the providers?

What results are you able to provide, as it pertains to wellness programs and initiatives?

Please identify any physicians and/or facilities that are currently at risk of leaving or in renewal negotiations that would impact the City based on their census.

I. UTILIZATION MANAGEMENT

A. General Questions

Are your UM services local, national or international? (Check [X] only ONE.)

- Local only
- National, some
- National, all
- National, all

Do you have educational material which informs enrollees regarding your UM services & procedures? (Check [X] only ONE.)

- Yes, available
- Yes, available
- No, but can c
- No, but can c
- No, not avail

B. Pre-Services Review (Pre-certification)

Do you have a standard pre-certification requirement for any of the following (Y / N)?

- Yes

If Yes, check [X] all applicable to your program:

- Hospitalizati
- Outpatient S
- Specified Dia
- Durable Mec
- Corrective Aj
- Skilled Nursi
- Home Health
- Musculoskel
- Medical Serv
- Inpatient Me
- Outpatient N
- Other _____

Precertification includes the analysis & determination of which of the following (may check [X] more than one)

- Appropriate
- Reasonable l



[Faded text area for review information]

- Actual medic surgery or se service requi
- Necessity for with each op
- Necessity for day
- Necessity for following OP
- Other (Explai

Indicate type of review information which is communicated to the claims payer by your firm:
 Appropriate level of care (e.g., OP):
 Do you notify claims payer?
 Approximate Frequency (check [X] only ONE):
 Method of Notification (check [X] only ONE):

- Yes
- Daily
- Weekly
- 2 x per mont
- Monthly
- Phone call
- Phone call +
- Letter or con
- Combination

Certified Length of Stay
 Do you notify claims payer?
 Approximate Frequency (check [X] only ONE):
 Method of Notification (check [X] only ONE):

- Yes
- Daily
- Weekly
- 2 x per mont
- Monthly
- Phone call
- Phone call +
- Letter or con
- Combination

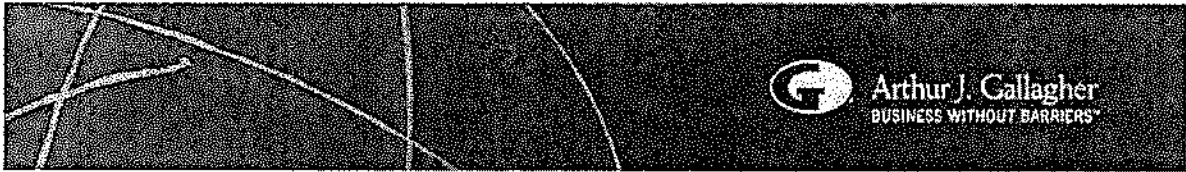
Procedure / Service determined NOT to be medically necessary
 Do you notify claims payer?
 Approximate Frequency (check [X] only ONE):
 Method of Notification (check [X] only ONE):

- Yes
- Daily
- Weekly
- 2 x per mont
- Monthly
- Phone call
- Phone call +
- Letter or con



<p>Indicate the primary method for determining the appropriate length of stay for a hospital admission. (Check [X] only ONE.)</p>	<input type="checkbox"/> Combination <input type="checkbox"/> HCIA/PAS by Year <input type="checkbox"/> Internally de <input type="checkbox"/> LOS not pre- <input type="checkbox"/> Other purcha <input type="checkbox"/> Other
<p>Within the past twelve months, in what % of all precertification cases was a letter of noncertification (denial) for Medical Necessity / Appropriateness for the procedure/service issued? (Answer may require specific justification at a future date.) (Check [X] only ONE.)</p>	<input type="checkbox"/> Less than 1% <input type="checkbox"/> 1 to 2% <input type="checkbox"/> 3 to 4% <input type="checkbox"/> 5 to 6% <input type="checkbox"/> 7 to 8% <input type="checkbox"/> More than 8% <input type="checkbox"/> Not applicab
<p>What % of ALL preservice reviews require your physician advisor review for decision making? (Check [X] only ONE.)</p>	<input type="checkbox"/> Less than 1% <input type="checkbox"/> 1 to 10% <input type="checkbox"/> 11 to 19% <input type="checkbox"/> 20 to 30% <input type="checkbox"/> 31 to 40% <input type="checkbox"/> 41 to 50% <input type="checkbox"/> Greater than
<p>C. Concurrent/Continued Stay Review</p>	
<p>Does your firm perform concurrent review services?</p>	<input type="checkbox"/> Yes
<p>Concurrent review staff are:</p>	<input type="checkbox"/> ___% Full-ti <input type="checkbox"/> ___% Part-ti <input type="checkbox"/> ___% Subcor on-call only, personnel) 1
<p>D. Case Management</p>	
<p>Describe in detail your large case/catastrophic case management program.</p>	<input type="checkbox"/>
<p>During case management, does your staff negotiate fee reductions with providers and vendors? (Check [X] only ONE.)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No, but willir <input type="checkbox"/> Fees not typi
<p>What is the average percent fee discount this client could expect your firm to negotiate for service / equipment, etc.? (Check [X] only ONE.)</p>	<input type="checkbox"/> 1 to 5% <input type="checkbox"/> 6 to 10% <input type="checkbox"/> 11 to 14% <input type="checkbox"/> 15 to 20%

	<input type="checkbox"/> 21 to 25% <input type="checkbox"/> 26 to 30% <input type="checkbox"/> More than 30%
Describe your catastrophic case management program.	
What reports will be provided?	
And with what frequency?	
E. Reporting	
Indicate your standard method of reporting savings from the review of IP hospitalization. (Check [X] only ONE.)	<input type="checkbox"/> IP hospital savings <input type="checkbox"/> Basically as requested or more <input type="checkbox"/> Basically as a percentage vs. normative <input type="checkbox"/> OP surgical review <input type="checkbox"/> OP surgical review as delineated <input type="checkbox"/> \$ value time: medically necessary <input type="checkbox"/> Other (describe)
Indicate your standard method of reporting savings from the review of OP surgery. (Check [X] only ONE.)	
F. Auditing	
Does your organization perform hospital bill audits?	<input type="checkbox"/> Yes
If yes, describe the program and the basis of your compensation.	
Does your organization offer disease management programs?	<input type="checkbox"/> Yes
Is your DM program developed internally, or provided through an outside vendor?	
If an outside vendor, indicate the name(s) of the firm(s).	
Describe any in- or out-of-state Centers of Excellence required by your plans.	
Does your stop-loss insurance require use of these facilities?	
What diagnoses / chronic conditions are covered?	
How do you identify potential DM candidates?	
What sources of data do you use?	
What DM interventions does your organization propose to provide? (Check [X] ALL that apply.)	<input type="checkbox"/> Written communication <input type="checkbox"/> Group education <input type="checkbox"/> One-on-one <input type="checkbox"/> Telephone review <input type="checkbox"/> Clinical intervention <input type="checkbox"/> Other (propose)
Describe your diabetic management approach.	



Do you offer metabolic syndrome programs? If so, please elaborate what you program entails.	
How will outcomes be reported for each proposed intervention?	
Give detailed information about the technology platforms you currently support, including: Hardware platforms (e.g., desktop, servers, etc.) Operating system(s) Database management software Communications protocols supported Distribution options and capabilities	
Describe how your program would interface with the Plan's: Prescription drug benefits include how your program would work differently, if applicable, with a carved-out PBM. Mental health benefits	
Describe your reporting capabilities and methodology.	
Are the following reports available to the client? If so, indicate frequency next to your response.	
Cost savings reports	<input type="checkbox"/> Yes Frequency__
Utilization reports	<input type="checkbox"/> Yes Frequency__
How do you measure the cost-effectiveness of your program?	
Are the costs included in your quotation?	<input type="checkbox"/> Yes
If not, what are the additional costs?	
Are you willing to guarantee return on investment (ROI)?	<input type="checkbox"/> Yes
If yes, please describe terms and conditions in detail.	

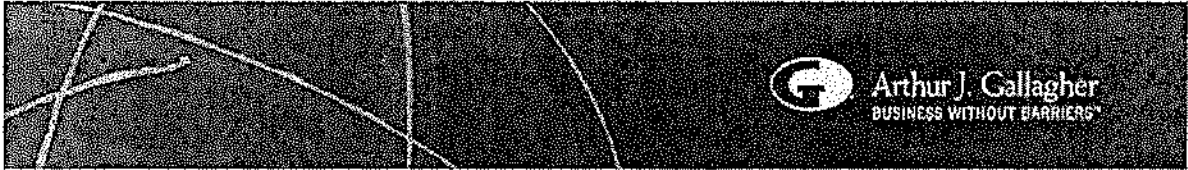
PERFORMANCE GUARANTEES (Please refer to Performance Guarantees Tab)

The City of Grand Island expects your organization to place a minimum of 20% c ongoing performance. The guarantees are designed to ensure high quality admi management for The City. They are not meant to be unreasonable or inflexible.

Please carefully review the suggested performance guarantees and complete the column provide the *percent* of annual fees committed to meeting the performa organization measures or calculates performance differently than specified in the accordingly and in a way that best matches the intent of the guarantee .

Confirm your ability/willingness to meet each of the standards shown below. Fo that you cannot meet, please state the reason, and propose an alternative.

The successful bidder will also be expected to place an additional 20% of annual implementation. Please confirm your acceptance of this requirement. You may a guarantee.



Complete the tables below (Table A is for ongoing administration and Table B is in the amount of fees you are offering to place at risk in each of the areas and in specification of the guarantees in terms of “% of fees at risk”. Proposals that dev responsive.

Are you offering any additional guarantees to the City of Grand Island? If so, ple. Unless you state otherwise, we will assume that all guarantees will be based on specific data. Please clearly indicate any exceptions to this assumption

DNSE

arrier response is provided in

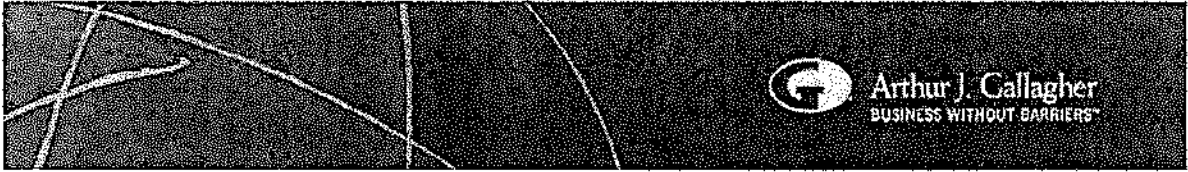
Disagree

Disagree

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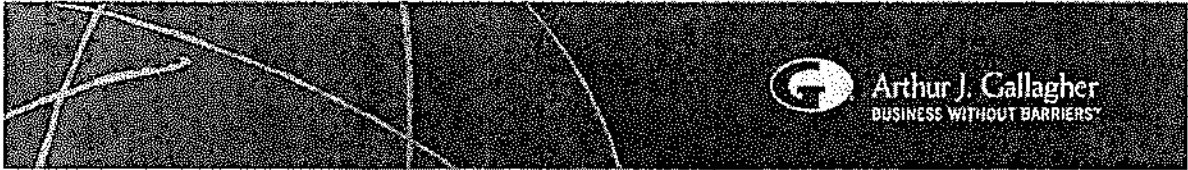
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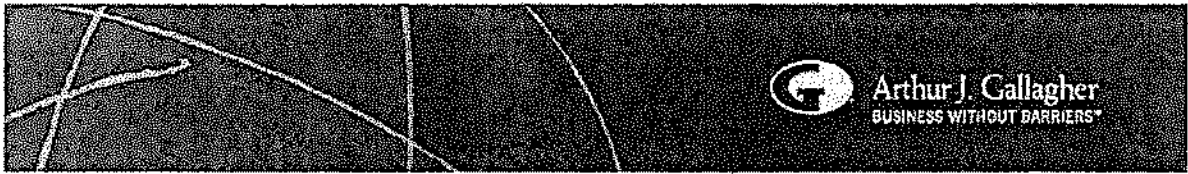


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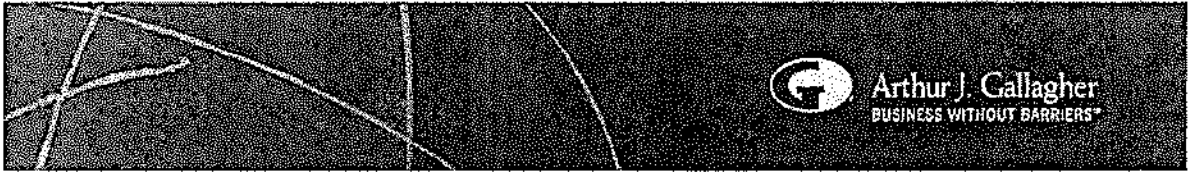


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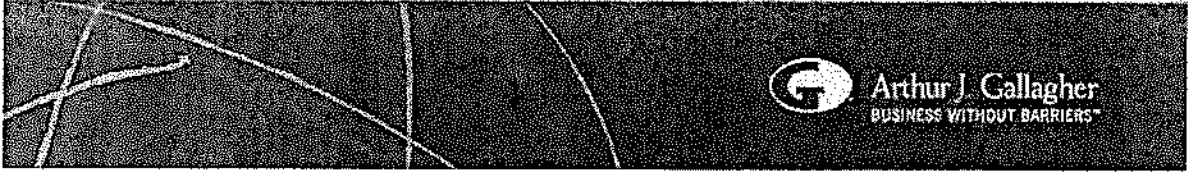




Plan Sponsors

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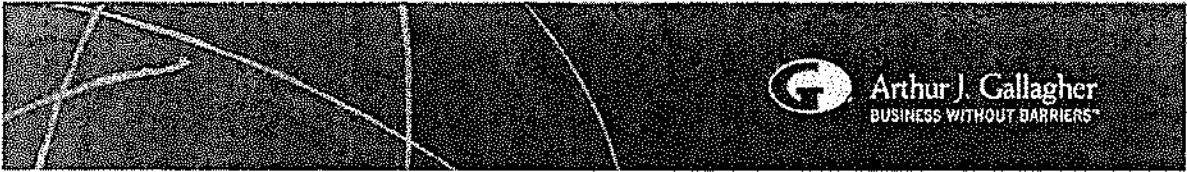


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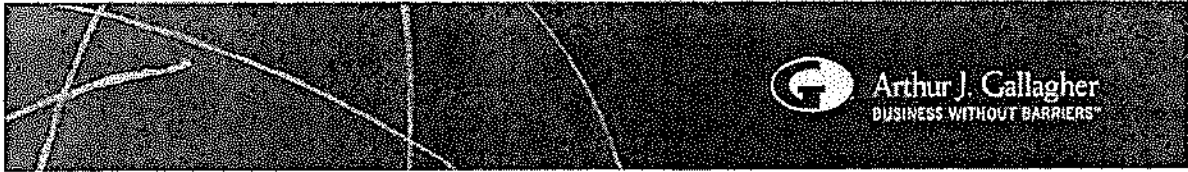


 No

- Monthly
- Quarterly
- Semi-annually
- Other (Describe)

 No
 No

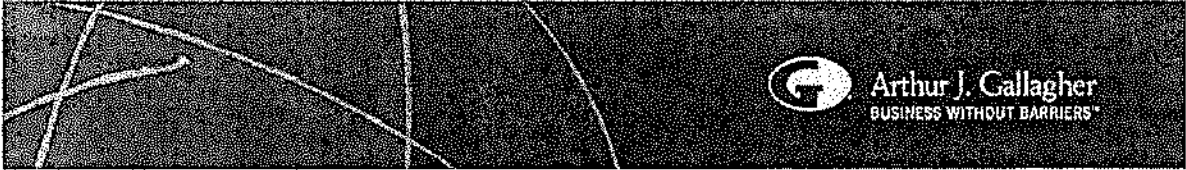
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 No

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 No



ne states

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at no additional cost

with an added cost of \$ _____

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Develop with an added cost of \$ _____

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lical Equipment

ppliances / Prosthetics

ng Facility

r Care

etal Services (e.g., chiropractic)

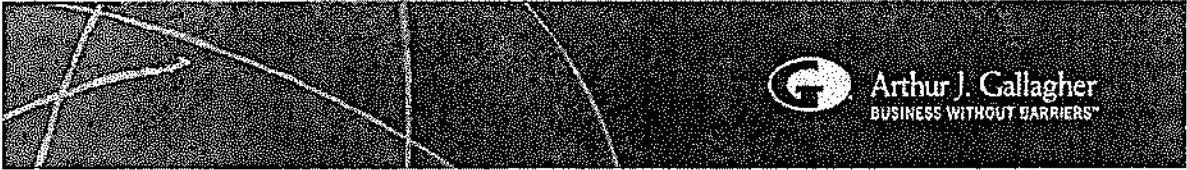
rices (e.g., physical therapy)

ental Health / Substance Abuse

Mental Health/Substance Abuse

level of care (e.g., IP vs. OP)

length of stay of IP confinement



al necessity & appropriateness of
ervice being requested (e.g., does
ire performance?)

the services of an assistant surgeon
erative procedure analysis

a proposed preoperative hospital

a proposed 23-hour observation stay
surgery

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No N/A

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written follow-up
nputer report
; specify

No N/A

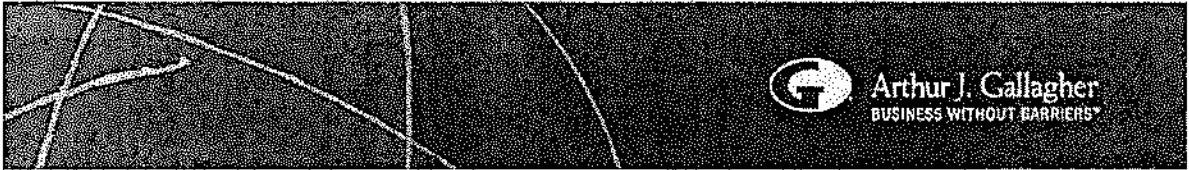
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written follow-up
nputer report
; specify

No N/A

h

written follow-up
nputer report



...; specify
... look for _____ (Region / Percentile /

... developed written LOS table

... assigned

... based written LOS table (specify)

... %
... le

... 50%

No

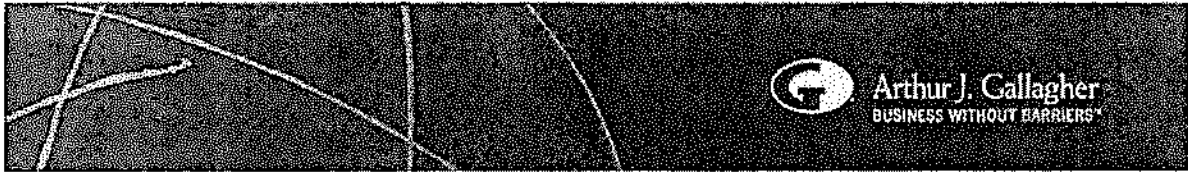
... ne EEs of the UM firm

... ne EEs of the UM firm

... tracted/consulting reviewers (e.g.,
... registry, home health agency
... 00% TOTAL

... ng to develop for this client

... ically negotiated



0%

ivings reports not available

he difference between days
nd days approved / certified.

i comparison of days or LOS utilized
e or case mix adjusted days or LOS.

review not available

available but specific reporting not

s the # of cases determined not to be
cessary
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No

No

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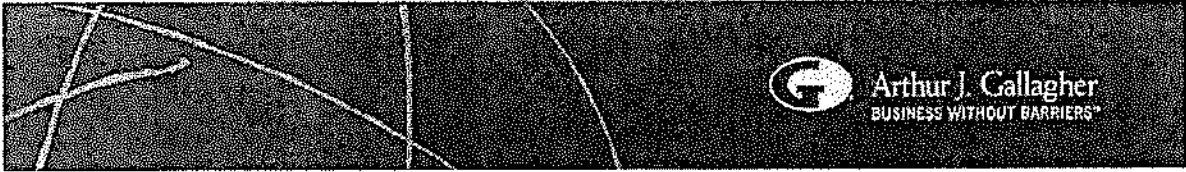
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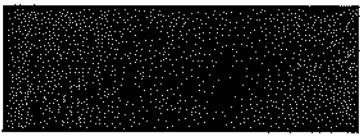


No

No

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No

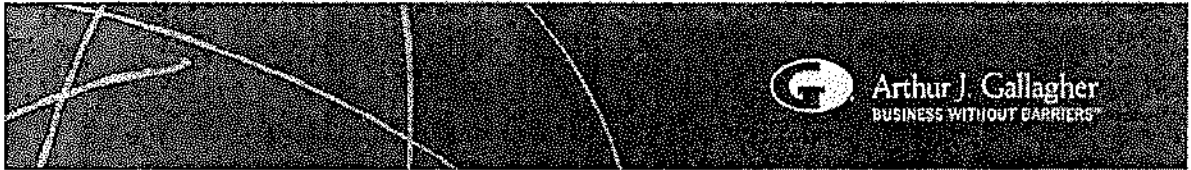


of annual fees at risk for
administration and account

the tables as indicated. In the last
12-month goal. *Note: If your
response exhibits, please modify*

for any standard or threshold

fees at risk for successful
also suggest a more generous



for implementation) by filling
total. Be sure to include
iate may be considered non-

ase detail.
the City of Grand Island-

GALLAGHER BENEFIT SERVICES, INC.
COVERAGE NOTICE

This proposal (analyses, report, etc.) is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal (analyses, report, etc.) is not a contract and offers no contractual obligation on behalf of GBS. Policy forms for your reference will be made available upon request.

This analysis is for illustrative purposes only, and is not a proposal for coverage or a guarantee of future expenses, claims costs, managed care savings, etc. There are many variables that can affect future health care costs including utilization patterns, catastrophic claims, changes in plan design, health care trend increases, etc. This analysis does not amend, extend, or alter the coverage provided by the actual insurance policies and contracts. See your policy or contact us for specific information or further details in this regard.