

**REQUEST FOR PROPOSAL
BID NUMBER
001048**

Bids are being solicited by Wayne County Community College District for Firms and Voluntary Employee Beneficiary Associations (VEBA) requesting alternatives to existing coverage in the areas of Health, Prescription, Dental, and Vision Benefit Services.

A Mandatory Pre-Bid Conference will be held at 3:00 p.m., Tuesday, June 23, 2009 at the following location:

**Wayne County Community College District
Central Administration Building
First Floor Conference Room
801 W. Fort Street
Detroit, MI 48226**

IMPORTANT: Your company is responsible for knowing any changes or modifications discussed at the Pre-Bid Conference. Those bids which do not meet specifications will be rejected. (FAXED BIDS WILL NOT BE ACCEPTED)

The deadline for questions will be Tuesday, June 30, 2009 at 12:00 p.m.

Following the Pre-Bid Conference, bids will be received by:

**All bids will be received by:
Mr. Jacob Keli
Associate Vice Chancellor Financial Operations and Special Initiatives
Wayne County Community College District
Purchasing Department – 4th Floor
801 W. Fort St.
Detroit, MI 48226
Voice: (313) 496-2781 / fax: (313) 961-7693**

The deadline for receipt of proposals will be Wednesday, July 22, 2009 at 3:00 p.m.

At that time, the bids will be opened publicly. Indicate on the outside of your (SEALED) envelope your company name, the Bid number, Project Name and the Deadline.

Information required from Bidders: (NOTE: Items 1 through 6 are required for all bids.)

Please return the following with your submission:

1. Proposal page(s), complete with authorized signature (if provided)
2. Proof of three (3) years in business
3. Proof of business insurance
4. References (a minimum of three)
5. Certificate of Awardability (available from the State of Michigan Civil Rights Office, ph. 313-456-3823; (a copy of a letter stating you have applied is sufficient)
6. Addendum to Independent Contractor Agreement (supplied by the College)
7. Financial Statement (required only if your total bid is \$50,000.00 or more)
8. Bid Guarantee (required if your total bid is \$50,000.00 or more)
9. Outline of any suggested modifications or an explanation of any proposal suggestion submitted by you, which may not be clear.

REQUIREMENTS IN DETAIL

1) PROPOSAL PAGE

Your bid proposal **must** be submitted on 8.5" x 11" paper; you may submit supporting documentation, etc. but the College reserves the right to dispose of said support (covers, oversize envelopes, etc.) at the completion of the bid.

2) PROOF OF THREE YEARS IN BUSINESS

Any company submitting a bid must show proof of being in business for at least three (3) years. The proof of three years in business must be supplied by the company submitting the bid and cannot be submitted by an umbrella company or a company previously operated by the principle agents. Proof of 3 years in business can be a copy of a three year old document bearing the company" name. These documents may include; Articles of Incorporation, bank statement, licenses, telephone bill, etc.

3) PROOF OF BUSINESS INSURANCE

Your company must be insured and possess the proper amounts of liability, workman's compensation, auto, etc., required by law. Please include a copy of your certificate with your bid. The contractor must be licensed to do business in the State of Michigan. The contractor's insurer must be one which is acceptable to the College. Insurance must be kept in force for the term of the contract; the retro-date must stay the same.

4) REFERENCES

References shall consist of a minimum list of clients (three) presently serviced by your company, for whom you perform the same or similar service(s), and a contact person with current phone number at each establishment.

5) CERTIFICATE OF AWARABILITY

Each contractor submitting a proposal must establish if he or she is awardable under criteria established by the Michigan Civil Rights Commission. A **Certificate of Awardability** must accompany your bid. Certificates may be obtained through the Michigan Civil Rights Commission Office located at 3054 W. Grand Blvd., Suite 3-600. Detroit, MI ; (phone: 313-456-3823). A letter stating that you have applied for the certificate is acceptable until receipt of the certificate.

6) ADDENDUM TO INDEPENDENT CONTRACTOR AGREEMENT

This document, supplied by the College, is required with most bids. This states that the contractor and employees including subcontractors **are not** employees of the College

7) FINANCIAL STATEMENT – Must be submitted with BIDS OF \$50,000.00 OR MORE. A financial statement covering the latest complete business cycle is required.

8) BID GUARANTEE

A certified check, bank cashier's check or bid bond equal to **five percent (5%)** of your total base bid is required for each bid; the items should be made payable to **Wayne County Community College District**. A bid bond shall be issued by a bonding company licensed to transact business in the locality.

The successful bidder's bid guarantee will be retained until he has entered into a contract with the College. The College reserves the right to hold the bid guarantee of the next two bidders until the successful bidder has entered into a contract with the College, or for a period of sixty (60) days, whichever time elapses first. Bid guarantees of all other bidders will be returned to them as soon as possible after the bid opening.

Should a bidder fail to enter into a contract with the College within ten (10) days, after his bid is accepted, his bid guarantee will be **forfeited** to the College as liquidated damages but not as a penalty.

A performance Bond and Labor and Material Bond for (100%) of the contract may be required for construction projects.

OTHER INFORMATION

ADDENDA

Addenda will be mailed, faxed or delivered to all who are known by WCCCD to have a complete set of bid documents. No addenda will be issued later than (24) hours prior to the bid opening date except for addenda withdrawing the bid or postponing the bid opening date.

EXPLANATION OF BID DOCUMENTS

Any bidders requesting clarifications or corrections to bid documents must put +their requests in writing and fax them to WCCCD Purchasing Department at 313-961-7693.

Clarification requests must be received no later than 3 days prior to the bid opening date.

BIDS EXCEEDING \$50,000.00

If the combined total of your bid on this package is \$50,000.00 or above, it is **MANDATORY** that all information requested in the previous section titled "Information Required from Bidders" be included in your bid package at the time of the bid opening to insure that your bid be considered.

WITHDRAWAL OF BIDS

Any bidder may withdraw his bid, either personally or by written request, at any time prior to the hour set for the bid opening. No bid may be withdrawn or modified later than the time set for opening unless and until the award of contract is delayed for a period exceeding sixty (60) days.

SUBMISSION OF FORMS

Proposals must be submitted on forms furnished by the College (if provided); forms may be requested in duplicate. Attachment(s) may be made to clarify or supplement the College form(s). Please note that outsized attachments and other supplemental submissions may be disposed of at the completion of the bid process.

TERMS

The College's terms are net 30, unless otherwise negotiated.

ACCEPTANCE OF BID PROPOSAL(S)

The College reserves the right to reject any or all bids; the College may waive any informalities or irregularities in bid proposals submitted during the bidding process. **The College also reserves the right to award the contract to other than the low bidder.**

Sealed bids may be submitted prior to the closing date in an envelope clearly marked with the **company name, bid number, title of the project and the date and time it is due**. The College accepts no responsibility for bids, which do not meet the deadline because they were improperly labeled.

“LOWEST RESPONSIBLE BIDDER”

The lowest responsible bidder shall be based upon the following criteria: (1) purchase price; (2) the reputation of the vendor and of the vendor's goods or services; (3) the quality of the vendor's goods or services; (4) adequate financial resources for performance; (5) the extent to which the goods or services meet the College's needs; (6) the vendor's past relationship with the College; (7) adequate experience, organization and technical qualifications, skills and facilities; (8) ability to comply with the required timeline for delivery of services or goods; (9) a satisfactory record of integrity, judgment and performance; (10) in form and substance, a commitment to MBE, WBE, and WCBE goals.

ADDENDUM TO INDEPENDENT CONTRACTOR AGREEMENT

This will confirm that I have informed Wayne County Community College District that I meet the four basic tests used by the General Accounting Office to determine whether a true separate business entity exists which permits the College to engage me as an independent contractor.

Those four basic tests are:

1. I have a principal place of business other than furnished by the College. I understand that a home does not qualify as a separate place of business unless it qualifies as a deduction of certain expenses in connection with business use of the home.
2. I maintain a separate set of books and records that reflect all items of income and expenses at my business.
3. I have the risk of suffering a loss as well as the opportunity of making a profit and
4. I hold myself out in my own name / Company name as self-employed and make my services generally available to the public.

In addition to meeting the above basic tests, I have read and understand the twenty-factor test set forth by the Internal Revenue Service at Rev Rul 87-41, 1987 which is used to determine whether an individual is an independent contractor, I generally meet the requirements, and hereby certify to Wayne County Community College District (WCCCD) that I am an independent contractor in accordance with the Internal Revenue Service twenty-factor test included therein.

Name of Independent Contractor

Name of Firm (if applicable)

Employer Identification Number

Date

**WAYNE COUNTY COMMUNITY
COLLEGE DISTRICT**

**Firms and Voluntary Employee Beneficiary Associations (VEBA)
requesting alternatives to existing coverage in the areas of Health,
Prescription, Dental, and Vision Services.
RFP 001048**

PROPOSAL PAGE

1. Company Name _____

2. Company Address _____

3. City _____ State _____ Zip Code _____

4. Authorized Company Signature _____

Printed name _____

Title _____

5. Phone number _____

6. Fax No. _____

D.R.M. Stakor & Associates, Inc.

June 7, 2009

Under the provisions of Public Employees Health Benefit Act (PA 106), Wayne County Community College District has requested D. R. M. Stakor & Associates, Inc. seek proposals for alternatives to their existing Health, Prescription, Dental, and Vision coverages. All information received will be held in confidence and remain unpublished to the extent the law allows.

This request for proposal has been organized into the following sections:

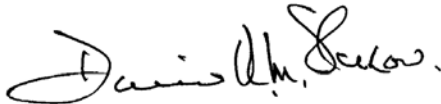
Timetable and Instructions Section 1
Summary of Current Plan Design..... Section 2
Requested Benefit Options..... Section 3
Census and Demographic Data..... Section 4
Claim Experience..... Section 5
Bid Form Section 6
Questionnaire..... Section 7
Affidavit of BidderSection 8

In the event you are interested in providing a proposal, please send a letter on your company's letterhead so stating your intent and confirming you are an insurance agent or carrier licensed in the State of Michigan. Please address your letter to

Mr. Jacob Keli,
Associate Vice Chancellor
WCCCD
801 W. Fort Street
Detroit, MI 48226

Census and Plan Design details will be available at the mandatory pre-bid meeting on June 23.

Sincerely,



David R.M. Stakor, LIC



D.R.M. Stakor & Associates, Inc.

Timetable and Instructions - Section 1

Consultant

D.R.M. Stakor & Associates, Inc.
900 Wilshire Drive, Suite 202
Troy, MI 48084
248-813-8700
248-813-0336 (Fax)

Group

Wayne County Community College District
801 W. Fort Street
Detroit, MI 48226

Coverage Desired

- 1) Health – note options requested in section #3
- 2) Prescription – note options requested in section #3
- 3) Dental
- 4) Vision

Timetable

Mandatory Pre-Bid Meeting:	June 23, 2009; 3 pm at WCCCD
Deadline for questions:	June 30, 2009; 12 noon
Deadline for letter of intent to respond:	July 3, 2009
Deadline for receipt of proposals:	July 22, 2009; 3 pm
Assumed Effective Date:	October 1, 2009

General Information

The Wayne County Community College District (WCCCD) provides Health coverage on a self-insured basis with Stop-Loss and Prescription Drug coverage on a self-insured basis. Dental and Vision coverages are on an insured basis. At this time, the District is exploring potential cost savings opportunities without change or making certain minor changes in the plan design and funding arrangement for all employee groups.

The Health, Prescription, Dental, and Vision benefits described in Summary of Current Plan - Section 2 provides a brief description of these benefits. Additional details will be found in the

D.R.M. Stakor & Associates, Inc.

plan benefit summaries that are included on the CD that will be available at the mandatory pre-bid meeting.

The bidding assessment will take into account value, provider relationships/networks, servicing, and overall ability to provide a quality replacement coverage. The assessment weight assigned to these proposal elements will place the greatest emphasis on value effectiveness, but a company's servicing capabilities and the accessibility of its provider relationships/networks will also be given significant importance.

Coverage, if accepted, must guarantee continuity of coverage with no, or with full advanced notice and District acceptance, selected changes in benefits.

Please note if your proposal includes or is net of commissions.

WCCCD reserves the right to reject any proposal in whole or in part.

Intent to Respond: Any party who intends to respond to this RFP shall submit an Intent to Respond, including the name of the contact person and the address, with fax number and e-mail address, to Jacob Keli at WCCCD no later than **July 3, 2009**.

Answers to questions received will be placed on the WCCCD website by June 26, 2009.

Release of Claims: Each Proposer by its submission of its Proposal releases D.R.M. Stakor & Associates, Inc. and WCCCD from any claims arising out of, and related to, the RFP process and selection of a Contractor.

Proposer Bears Proposal Costs: A recipient of the RFP is responsible for any and all costs incurred by it or others acting on its behalf in preparing or submitting a Proposal, or otherwise responding to the RFP, or any negotiations incidental to its Proposal or the RFP.

General Instructions

1. Please submit three originals of your proposal to Stakor, Inc., by the deadline above.
2. Questionnaire and bid forms enclosed **must** be completed in their entirety.
3. Any and all deviations from the specifications must be identified in your questionnaire responses or cover letter. In the absence of a specific deviation, we will assume and accept your illustrative proposal as providing identical coverage.

Summary of Current Plan - Section 2

Please note that it is the intent of the bidding that coverage be identical to the plans being bid and also with some plan modifications.

1. Health Coverage

All groups are provided the option of healthcare through Blue Cross Blue Shield of Michigan, HAP or Total Health Care. Below is a brief summary of the plans. Please refer to the data on the disk for further detail.

Blue Cross Blue Shield: Community Blue for all except 3 employees

In-network:

Co-payment requirements:

- \$10 co-payment per office,
- \$10 co-payment per office consultation
- \$10 co-payment for urgent care visits
- 100% for hospital emergency room
- 50%co-payment for Inpatient substance abuse treatment with 60 day per member per calendar year to a lifetime maximum of 120 days for Mental health care and substance abuse treatment
- 50% co-payment for outpatient substance abuse treatment in an approved facility up to state-dollar amount that is adjusted annually.
- 50% co-payment for Private duty nursing

Out-of-network:

Deductible requirements:

- \$250 individual/\$500 family

Preventive Care - not covered

Co-payment requirements:

- 50% co-payment of the approved amount for private duty nursing services
- 20% co-payment of the approved amount for most other services
- Mental health care and substance abuse treatment comparable to in-network

Annual co-payment maximum:

- \$2,000 for one member
- \$4,000 for two or more members

Lifetime Maximum Benefit: \$1millin per covered specified human organ transplant and a separate \$5million for all other covered services as noted.

Blue Cross Blue Shield: Blue Managed Traditional First Dollar with Master Medical for 3 employees - Grandfathered

Please refer to disk for plan detail. Please note: claim data has been omitted for this suffix due to only 3 employees enrolled.

Health Alliance Plan (HAP):

- \$0 deductible in network; no out-of-network benefits
- Medically necessary office visits \$0 co-pay per visit; no out-of-network benefits
- Routine/preventive \$0 co-pay per visit; no out-of-network benefits
- Inpatient hospital services/days of care: unlimited
- Emergency/Urgent care covered at 100%
- Therapy benefits paid in-network up to 60 visits per condition per lifetime
- Outpatient mental health services covered in-network with maximum of 20 visits per calendar year
- Inpatient mental health services up to 45 days, renewable after 60 days.
- Outpatient chemical dependency services covered in-network with a maximum of 35 visits per calendar year
- Inpatient chemical services up to 45 days, renewable after 60 days.
- Home Health Care covered
- Hospice Care covered up to 210 days.
- Skilled Nursing Care in Convalescent Facility covered up to 730 days, renewable after 60 days.
- Assisted Reproductive Technology covered for one attempt of artificial insemination pre lifetime.
- Annual co-payment maximum: N/A
- Lifetime maximum benefit: Unlimited

Total Health Care

This is an HMO plan. Participation in the plan is limited to part-time and certain full-time faculty and staff. The District pays the premium for the full-time employees. Premiums for part-time employees are paid 100% by the employees through payroll deduction.

The monthly premiums as of April 1, 2009 are:

Single	\$399.66
Double	\$832.89
Family	\$1,059.50
Family Continuation	\$279.76

- \$0 deductible in network; no out-of network benefits
- Physician Services \$5 co-pay per visit
- Maternity Services covered
- Inpatient Hospital Services covered
- Outpatient Procedures covered
- Emergency & Urgent Care Medical Services
 - Physician and hospital emergency room services (copay waived if admitted) \$40
 - Participating urgent care centers \$0
 - Ambulance services (when medically necessary) \$75

D.R.M. Stakor & Associates, Inc.

- Diagnostic & Therapeutic Services covered
- Mental Health Care covered
 - Outpatient treatment (limited to 20 visits/year)
 - Inpatient psychiatric hospital services (limited to 45)
- Substance Abuse Treatment Covered
 - Outpatient and intermediate care (limited to state mandated levels)
- Durable Medical Equipment & Prosthetic Devices
- Alternate Medical Systems Covered
 - Home health care (limited to 100 visits/year)
 - Skilled nursing home care (limited to 45 days lifetime max)
 - Hospice care
 - Home health aid care
- HEARING SERVICES Covered
 - Hearing exam and hearing aid testing
 - Hearing aid (limited to 1 every three years)
- Vision Services Covered
 - Eye exam (limited to 1/year)
 - Eyeglasses (limited to 1 pair every two years)

2. Prescription Drug

BCBSM for Full-Time AFT and P & AA employees

Participating Pharmacy:

- No-copayment with 100% coverage

BCBSM for Full-Time Exempt and UAW employees

Participating Pharmacy:

- \$5 co-payment for generic drugs
- \$5 co-payment for over-the-counter drugs when covered by BCBSM
- \$10 co-payment for brand name drugs including single-source drugs where no generic is available
- No-copayment for Mail order prescription drugs

HAP

- \$2 co-payment for all drugs
- Birth Control Pills covered

Total Health Care

All pharmaceuticals prescribed by a THC participating provider and filled through a THC participating pharmacy

MAIL ORDER RX AVAILABLE

\$0/generic

\$10/brand*

3. Dental Coverage

All full-time employees are provided dental coverage through Delta Dental.

	Plan Pays	You Pay
Class I Benefits		
Diagnostic and Preventive Services - includes exams, cleanings, fluoride, and space maintainers	90%	10%
Emergency Palliative Treatment - to temporarily relieve pain	90%	10%
Brush Biopsy - to detect oral cancer	90%	10%
Radiographs - X-rays	90%	10%
Class II Benefits		
Major Restorative Services - includes crowns	90%	10%
Minor Restorative Services - includes fillings	90%	10%
Periodontic Services - to treat gum disease	90%	10%
Endodontic Services - includes root canals	90%	10%
Oral Surgery Services - extractions and dental surgery	90%	10%
Relines and Repairs - to bridges and dentures	90%	10%
Other Basic Services - misc. services	90%	10%
Class III Benefits		
Prosthetic Services - includes bridges and dentures	90%	10%
Implants - endosteal implants to replace missing teeth	90%	10%
Class IV Benefits		
Orthodontic Services - includes braces	50%	50%
Orthodontic Age Limit -	To age 19	

- Oral exams are payable twice in any period of 12 consecutive months.
- Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months.
- Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.
- Bitewing X-rays are payable once in any period of 12 consecutive months and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.
- People with certain high-risk medical conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- **Maximum Payment** - \$1,000 per person total per benefit year on all services except Orthodontics. \$500 per person total per lifetime on Orthodontic Services

4. Vision Coverage

All full-time employees have the choice of selecting vision coverage through either Heritage Vision Or Co/op Optical

Heritage Vision Plans

SERVICES	COVERAGE FREQUENCY	IN-NETWORK: COVERAGE
Comprehensive Eye Exam For Eyeglasses (Does not apply to Contact Lens Exam)	Once every 24 months (from date of last exam)	Fully Covered, No Co-pay
Frames	Once every 24 months (from date of last purchase)	Covered up to a \$125 maximum
Lenses: (Choice of One)		
Single Vision	Once every 24 months (from date of last purchase)	Fully Covered, No Co-pay
Bifocal	Once every 24 months (from date of last purchase)	Fully Covered, No Co-pay
Trifocal	Once every 24 months (from date of last purchase)	Fully Covered, No Co-pay
Lenticular	Once every 24 months (from date of last purchase)	Fully Covered, No Co-pay
Lens Options:		
Tint (Therapeutic Rose Tint #1 or #2)	Once every 24 months (from date of last purchase)	Fully Covered, No Co-pay
Frame Warranty (1 year manufacturer's)	Once every 24 months (from date of last purchase)	Fully Covered, No Co-pay
OR		
Contact Lenses -\$129.00 Allowance towards Exam and Contact Lenses		
Comprehensive Eye Exam For Contact Lenses 1 (Applies to Contact Lens Exam and Fitting)	Once every 24 months (from date of last purchase)	Contact Exam and Fitting: Covered up to a \$64.50 maximum
Contacts Lenses 1 (includes disposables)	Once every 24 months (from date of last purchase)	Contact Lenses: Covered up to a \$64.50 maximum

Co/Op Optical

ELIGIBILITY

Eligible employees, their spouses, dependent children until their 25th birthday, and dependent mentally and/or physically handicapped children living at home are entitled to benefits once every 12/24 months.

Prior usage under a Co/op Optical Vision Designs Vision Program will be considered in determining

the 12/24 months eligibility limit. This contract is non-assignable.

ONCE EVERY 12 MONTHS

- Eye examination with no co-pay every 12 months, by a Co/op Optical Vision Designs optometrist, or a network provider ophthalmologist. (Select Network Provider ophthalmologists perform diagnostic examinations only and do not give contact exams or dispense contact lenses or glasses for this account).

ONCE EVERY 24 MONTHS

- Prescription Lenses, in plastic
 - Single Vision
 - Bifocal thru D-35
 - Trifocal thru 7x28
 - Tint: Plastic, any single color to 30%
 - One frame with a \$100.00 allowance toward any frame of choice.
- OR**
- A \$114.00 allowance toward a contact examination, lenses, and professional follow-up care (In lieu of eyeglass services).
 - 30-Day Guarantee: From date of delivery

COORDINATION OF BENEFITS

If you or a family member is covered under another vision care program, coordination of benefits may occur. Coordinated benefits will not exceed the maximum benefit level under either program.

Requested Quoted Benefit Options - Section 3

1. Healthcare::

- a. Mirror existing plans; HMO, PPO and Traditional Plan. As previously state, there are 3 employees who are grandfathered in the Traditional type BCBSM plan
- b. HMO Plan with \$5 office visit
- c. HMO Plan with \$10 office visit
- d. Community Blue Plan 1 type with \$10 office, \$20 urgent care and \$10 chiropractic copay
- e. Community Blue Plan 1 type with \$20 office; \$30 urgent care and \$20 chiropractic copay
- f. Cost reduction to add Emergency Room copay at \$50, waived if true emergency or admitted
- g. Cost reduction to add Emergency Room copay at \$75, waived if true emergency or admitted
- h. Cost reduction to add Emergency Room copay at \$100, waived if true emergency or admitted
- i. Cost reduction to add \$100 single/\$200 family in network (\$200/\$400 out of network) deductible to Community Blue Plan 1
- j. Cost reduction to add \$500 single/\$1,000 family in network (\$1,00/\$2,000 out of network) deductible to Community Blue Plan 1
- k. The District is interested in PPO plan options and is exploring offering a Cafeteria of plans. Attachment 2 outlines the additional plan options that are to be included in your proposal.

D.R.M. Stakor & Associates, Inc.

2. Prescription Drugs:

- a. Mirror existing plans
- b. Cost reduction to change to \$0 OTC¹; \$5 generic; \$10 brand with no generic available or brand with prior authorization; \$20 brand name; MOD 2 x retail copay, with generic enforcement (member who selects a brand with a generic will pay the higher copay PLUS the difference in the cost of the brand and generic)
- c. Cost reduction to change to \$5 OTC; \$10 generic; \$20 brand with no generic available or brand with prior authorization; \$30 brand name; MOD 2 x retail copay, with generic enforcement (member selects a brand with a generic pays the higher copay PLUS the difference in the cost of the brand and generic)
- d. Cost differential between 1 copay and 2 copays for Mail Order Drugs
- e. Cost reduction to change to \$20 generic; \$40 brand name with or without generic; and 2 copays for Mail Order Drugs
- f. 90/10 coinsurance on all prescriptions with the employee out of pocket maximum of \$1500/\$3000 per calendar year.

3. Dental

- a. Mirror existing plan
- b. Cost adjustment to change to 100% for Class I Benefits; 80% for Class II Benefits; 50% for Class III Benefits

4. Vision

- a. Mirror existing plans

5. Financial

- a. Insured
- b. Self Insured

6. Other – You are welcome to include plan and cost recommendations

¹ OTC Over The Counter drugs to be covered at zero (\$0) copay are Proton Pump Inhibitors (PPI) such as Prilosec and Non-Sedating Antihistamine (NSA) such as Claritan, Loratadine, Alavert and Zyrtec. Prescriptions are required.

D.R.M. Stakor & Associates, Inc.

Census and Demographic Data - Section 4

Census information is included on the disk.

Claim Experience - Section 5

Claim experience is included on the disk. Please also let us know if you would like additional data for a disruption analysis or claim repricing as these may result in Hold Harmless Agreements. As note earlier, the claims data for BCBSM suffix 000 has been deleted as there are only 3 employees enrolled

Bid Form - Section 6

General Information

Carrier: _____

Address: _____

Phone: _____

Contact: _____

Title: _____

Claim Office Location(s): _____

Questionnaire - Section 7

A. General Administration

1. Please provide a sample monthly billing statement.
2. Please provide a sample contract.
3. If you are awarded the business, how soon will the first billing statement be issued?
4. If awarded the business, how much lead-time is needed?
5. If awarded the business, what installation support is provided?
6. Do you have an on-line eligibility system?
7. Please provide sample management reports.

B. Organizational

1. Please provide an overview of your organization.
2. If awarded the business, who will service this account, and where?
3. What is the availability of a customer service representative for the pharmacy?

C. Provider Arrangements

1. Provide a brief history of the formation of your PPO network(s).
2. Please illustrate your local network membership enrollment:

Date	PPO
As of 1/1/09	
As of 1/1/08	
As of 1/1/07	

D.R.M. Stakor & Associates, Inc.

3. Please illustrate your local Provider Network:

Date	PPO/PCP	PPO/Specialist	PPO/Hospitals
As of 1/1/09			
As of 1/1/08			
As of 1/1/07			

4. Describe your organization's relationship to its network (owned, affiliated or leased).

5. Can you maintain provider contract arrangements in your system including:

- DRG's
- Per Diems
- Percentage of charges
- Percentage of an R & C percentile
- Other fee schedule amounts

6. Can you maintain more than one PPO and more than one fee schedule per PPO within your system?

D. Prescription Drug/ Pharmacy Benefit Management

Please complete the following:

	<u>Retail</u>	<u>Mail</u>
AWP Discount Brand		
AWP Discount Generic		
Dispensing Fee Brand		
Dispensing Fee Generic		
Administration Fee (per claim without commission)		
Formulary Rebate		

Are you able to administer Coordination of Benefits or Primary Payor within the prescription drug program?

D.R.M. Stakor & Associates, Inc.

E. Financial – Please provide for each of the plans and identify plan exceptions. Please provide illustrative rates for self-insured and insured rates as appropriate for each option.

- 1. Health Care:
 - a) Single rate
 - b) 2 Person rate
 - c) Family rate

- 2. Dental Care:
 - a) Single rate
 - b) 2 Person rate
 - c) Family rate

- 3. Vision care:
 - a) Single rate
 - b) 2 Person rate
 - c) Family rate

- 4. Vision Care:
 - a) Single rate
 - b) 2 Person rate
 - c) Family rate

F. Procedure Codes – Please provide the covered expenses expressed in a dollar amount for the following procedures for zip code 48226:

Procedure Code		Covered Expenses expressed in dollar amount
99392	Periodic preventive medicine reevaluation and management of an individual including a comprehensive history, comprehensive examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnosis	
99391	Periodic preventive medicine reevaluation and management of an individual including a comprehensive history, comprehensive examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnosis.	
99285	Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and mental status: a comprehensive history -- a comprehensive	
99283	Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history -- an expanded problem focused examination -- and medical decision making of moderate complexity.	

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99244	Office consultation for a new or established patient, which requires these three key components: a comprehensive history -- a comprehensive examination -- and medical decision making of moderate complexity. Counseling and/or coordination of care with other	
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history -- an expanded problem focused examination -- medical decision making.	
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history -- a detailed examination -- medical decision making of moderate complexity.	
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history -- a comprehensive examination -- and medical decision making of moderate complexity. Counseling and/	
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history -- an expanded problem focused examination -- and straightforward medical decision making..	
98941	Chiropractic manipulative treatment (CMT); spinal, three to four regions.	
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions.	
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.	
97012	Application of a modality to one or more areas; traction, mechanical	
90807	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face to face with the patient; with medical evaluation and management services.	
90801	Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circum.	
88305	Level IV - Surgical pathology, gross and microscopic examination Abortion - Spontaneous/Missed Artery, Biopsy Bone Marrow, Biopsy Bone Exostosis Brain/Meninges, Other than for Tumor Resection Breast, Biopsy Breast, Reduction Mammoplasty Bronchus, Biopsy C.	
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar.	
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care.	
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple.	

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G. Financial – If your quotation is based on a level of specific stop loss that is not the same as the level contained in the incumbent carrier’s claims experience, please indicate the applicable adjustment to the claims experience in your forecast that accounts for the difference.

H. Financial – Administrative Services Only

1. Please provide a complete breakdown of your retention costs including the following:

- a) Claims Administration _____
- b) General Administration _____
- c) Actuarial Services _____
- d) Legal and Compliance Services _____
- e) Premium Taxes _____
- f) Margin _____
- g) Risk Fees _____
- h) PPO Access Fees _____
- i) Other _____

2. Please provide the past three years of percentage increases/decreases for ASC retention costs.

3. Please provide the ASO Fee; Stop Loss Fee; Aggregate Stop Loss Fee; Risk Fee; and claim projection on a 12 month (mature year) basis.

- a) ASO Administrative Fee _____
- b) Specific Stop Loss Threshold _____
- c) Specific Stop Loss Fee _____
- d) Aggregate Stop Loss Threshold _____
- e) Aggregate Stop Loss Fee _____
- f) 12 month (mature) claim projection _____

4. Please identify any other service fees _____.

5. Please provide information on past increases of service fees for ASC fees.

6. Will your organization include a performance guarantee? If so, fully describe.

7. Please describe what the increases have been in your service fees for the past 3 years and what you anticipate in the future.

8. Is there a separate charge to access the PPO provider network? If so, provide details.

I. Financial - Insured Plans

1. Please provide a complete breakdown of your retention costs including the following:

- a) Claims Administration _____
- b) General Administration _____
- c) Actuarial Services _____
- d) Legal and Compliance Services _____
- e) Premium Taxes _____
- f) Margin _____
- g) Risk Fees _____
- h) Other _____

2. Please provide the past three years of percentage increases/decreases for insured retention costs.

3. Please provide the following:

- a) Specific Stop Loss Threshold _____
- b) First year claim projection _____
- c) 12 month (mature) claim projection _____

4. Will your organization include a performance guarantee? If so, what do you offer?

5. Please identify any other service fees _____.

J. Rating and Projection Specifics:

- 1. What number of months of claims will be used for the first renewal?
- 2. What were the claims total used as the basis for the beginning of your proposed rates?
- 3. Did the beginning claims total include large specific claims in the total?
- 4. How many of the large claims used in the beginning claims total were for conditions that may be claimed into the future vs. terminal diagnosis?
- 5. Actuarially, how many large claims, and the amounts of each, can be predicted for the first renewal period.
- 6. What trend was used for the first full renewal period?
- 7. For what period, in months, was the trended claims total?
- 8. Was/is margin, risk charges, or other non specific retention elements used in your rates? Please fully describe each element used.

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- K. Please provide details on any exceptions to the current plans:
- L. Will you co-exist with another carrier?
- M. Please provide your financial ratings.
- N. Please provide any additional information that will assist us in reviewing your proposal

An officer of the corporation must sign this questionnaire:

Submitted by: _____ Date: _____

Title _____

Attachment 1 Additional Plan Options

Plan Option I

In-network:

Annual Deductible requirements:

- \$100 for one member
- \$200 for the family (when two or more members are covered under the contract)
- Deductible is waived if service is performed in a PPO physician's office

Copays requirements:

- Fixed dollar copays:
 - \$10 for office visits
 - \$50 for emergency room visits, waived if admitted or for an accidental injury
- Percent copays:
 - 10% for general services, copay waived if service is performed in a PPO physician's office
 - 50% for mental health care, substance abuse treatment, and private duty nursing

Annual Copay dollar maximums:

- Fixed dollar copays:
 - None
- Percent copays (excludes mental health care, substance abuse treatment, & private duty nursing):
 - \$500 for one member
 - \$1,000 for two or more members

Includes Preventive care services, \$500 per member per calendar year

Covered - 100%:

- Prenatal & postnatal care
- Hospice care
- Presurgical consultations
- Human organ transplants
- Allergy testing & therapy

Out-of-network:

Annual Deductible requirements:

- \$250 for one member
- \$500 for the family (when two or more members are covered under the contract)
- Out-of-network deductible amounts also apply toward the in-network deductible

Copays requirements:

- Fixed dollar copays:
 - \$50 for emergency room visits, waived if admitted or for an accidental injury
- Percent copays:
 - 30% for general services
 - 50% for mental health care, substance abuse treatment, and private duty nursing

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Annual Copay dollar maximums:

- Fixed dollar copays:
 - None
- Percent copays (excludes mental health care, substance abuse treatment, & private duty nursing):
 - \$1,500 for one member
 - \$3,000 for two or more members
 - Out-of-network copays also apply toward the in-network maximum

Covered - 100%:

- Hospice care

Covered - 90% after deductible:

- Ambulance services (must be medically necessary)
- Skilled nursing care
- Home health care (must be medically necessary)
- Home infusion therapy (must be medically necessary)

Benefits for the following coverages are subject to plan limitations (combined in- and out-of-network providers):

- Mammography screening
- Skilled nursing care
- Hospice care
- Human organ transplants
- Inpatient substance abuse treatment
- Outpatient substance abuse treatment
- Chiropractic manipulation treatment and osteopathic manipulation treatment
- Outpatient physical, speech, & occupational therapy

Lifetime Maximum Benefit: \$1 million lifetime per covered specified human organ transplant type and a separate \$5 million lifetime per member for all other covered services and as noted for individual services. Lifetime maximum applies to combined in-network and out-of-network benefits.

Plan Option II

In-network:

Annual Deductible requirements:

- \$1,000 for one member
- \$2,000 for the family (when two or more members are covered under the contract)
- Deductible is waived if service is performed in a PPO physician's office

Copays requirements:

- Fixed dollar copays:
 - \$30 for office visits; office consultations; urgent care visits; chiropractic manipulation treatment and osteopathic manipulation treatment up to max of 24 visits per calendar year
 - \$50 for emergency room visits, waived if admitted or for an accidental injury
- Percent copays:
 - 100% for general services, Deductible waived if service is performed in a PPO physician's office
 - 50% for mental health care, substance abuse treatment, and private duty nursing

Includes Preventive care services, \$500 per member per calendar year

Other covered benefits include -

- 100% not subject to deductible; Hospice care subject to dollar maximum that is reviewed and adjusted periodically.
- 100% after deductible; Skilled Nursing up to 120 days per member per calendar year

Out-of-network:

Annual Deductible requirements:

- \$2,000 for one member
- \$4,000 for the family (when two or more members are covered under the contract)
- Out-of-network deductible amounts also apply toward the in-network deductible

Copays requirements:

- Fixed dollar copays:
 - \$50 for emergency room visits, waived if admitted or for an accidental injury
- Percent copays:
 - 80/20% for general services
 - 50% for mental health care, substance abuse treatment, and private duty nursing

Annual Copay dollar maximums:

- Fixed dollar copays:
 - None
- Percent copays (excludes mental health care, substance abuse treatment, & private duty nursing):
 - \$3,000 for one member
 - \$6,000 for two or more members
 - Out-of-network copays also apply toward the in-network maximum

Other covered benefits include -

- 100% not subject to deductible; Hospice care subject to dollar maximum that is reviewed and adjusted periodically.

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- 100% after deductible; Skilled Nursing up to 120 days per member per calendar year

Benefits for the following coverages are subject to plan limitations (combined in- and out-of-network providers):

- Mammography screening
- Skilled nursing care
- Hospice care
- Human organ transplants
- Inpatient substance abuse treatment
- Outpatient substance abuse treatment
- Chiropractic manipulation treatment and osteopathic manipulation treatment
- Outpatient physical, speech, & occupational therapy

Lifetime Maximum Benefit: \$1 million lifetime per covered specified human organ transplant type and a separate \$5 million lifetime per member for all other covered services and as noted for individual services. Lifetime maximum applies to combined in-network and out-of-network benefits.

Plan Option III

High Deductible Health Care Plan (HDHCP) with Health Savings Account (HSA) that will be the responsibility of the employee to fund

In-network:

Annual Deductible requirements:

- \$1,250 for a one-person contract
- \$2,500 for a family contract (2or more members)
- no 4th quarter carry-over

Copay requirement: None

Includes preventive care services, no deductible or copay \$500 maximum per member per calendar year

Out-of-network:

Annual Deductible requirements:

- \$2,500 for a one-person contract
- \$5,000 for a family contract (2 or more members)
- No 4th quarter carryover

Copay requirement (once deductible requirement has been met):

- 20% of approved amount

Annual Copay dollar maximums:

- \$2,000 for a one-person contract
- \$4,000 for a family contract (2 or more members)

Covered - 100% after in-network deductible:

- Hospital emergency room
- Ambulance services (must be medically necessary)
- Hospice care
- Home infusion therapy (must be medically necessary)
- Outpatient substance abuse treatment
- Durable medical equipment
- Prosthetic and orthotic appliances
- Private duty nursing services
- Human organ transplants

Benefits for the following coverages are subject to plan limitations (combined in- and out-of-network providers):

- Mammography screening
- Skilled nursing care; limited to 90 days per member per calendar year
- Hospice care
- Home health care (must be medically necessary); by participating home health care agency only.
- Colonoscopy
- Human organ transplants
- Inpatient mental health care & substance abuse treatment
- Outpatient mental health care

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- Outpatient substance abuse treatment
- Osteopathic & chiropractic spinal manipulation treatment
- Outpatient physical, speech, & occupational therapy

Lifetime Maximum Benefit: \$1 million lifetime per covered specified human organ transplant type and a separate \$5 million lifetime per member for all other covered services and as noted for individual services. Lifetime maximum applies to combined in-network and out-of-network benefits.

Prescription Drug Coverage to be quoted with this plan with 2x copay for Mail Order Drug (MOD).