Exhibit A – Scope of Services, represents the minimum services to be provided by Contractor. Failure to meet performance standards may result in Contract non-renewal or cancellation.

1. **GENERAL INFORMATION**
	1. Services shall be for Administrative Services Only (ASO) with an effective date of October 1, 2024. All benefit tracking and accumulators must track to a 10/1 plan year.
	2. Contractor shall have experience in providing ASO to four or more employers each having 1,000 or more subscribers within the past five years.
	3. Contractor shall have accreditation by the National Committee for Quality Assurance (NCQA) or another nationally recognized accreditation organization as of the proposal due date.
	4. Health Plan proposals are requested for ASO, which are to include Behavioral Health and Pharmacy Services for active employees, Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) Participants, retirees, and eligible dependents.
	5. Pharmacy only proposals from independent Pharmacy Benefit Managers are not being requested.
	6. Contractor shall propose a total of two plan options: one plan that matches the current PPO health plan and one plan that matches the HMO health plan with the understanding the County may alter, increase, or decrease the plans in the future.
	7. Hospital provider networks for the plans matching the current health plan benefits shall include both Orlando Health and AdventHealth.
	8. ASO fee guarantees shall be included in all self-funded proposals for the initial term of five (5) years and are requested for the additional renewal for up to five (5) additional years (10 years total).
	9. Proposals shall be submitted net of commissions.
2. **MEDICAL AND PHARMACY ADMINISTRATIVE SERVICES**
	1. Contractor must provide a copy of their System and Organization Controls 1 (SOC1) or System and Organization Controls 2 (SOC 2) report annually to the County and/or County auditor. If these two reports are not available then a copy of their Statement on Standards for Attestation Engagements (SSAE) No. 18, Service Organizations must be provided. Preference is provided for SOC 1 and SOC 2 reports.
	2. Contractor shall complete Attachment 3 – References Form included with this RFP.
	3. Contractor will have accessible hours of customer service, a designated customer service team familiar with the County’s plan design and claims administration and demonstrated service results to administer the comprehensive health plan, including all medical and prescription drug benefits for active employees, COBRA participants, retirees, and eligible dependents.
	4. Contractor will have an experienced, dedicated account management team assigned to the County to assist with claims, eligibility, and day-to-day service issues.
	5. All customer service support involving interaction with members shall be handled within the territorial limits of the United States of America.
	6. Contractor shall attend at least semiannual meetings to review plan performance; meet monthly to review ongoing administrative services and plan management issues; and make available a Medical and/or Pharmacy Director for ongoing involvement in plan performance initiatives
	7. Web-based administrative tools will be made available to the County benefits department to view eligibility on an ongoing basis.
	8. Contractor will provide ADA compliant, web-based informational and educational tools, including online and via mobile app, to Plan participants providing information on issues such as claims status, explanation of benefits (EOBs), network providers by specialty, health and wellness topics, and provider / treatment cost calculators based on specific plan designs of the County.
	9. Contractor will prepare and maintain the Summary Plan Description (SPD) and annually required Summary of Benefits and Coverage (SBC) on behalf of the County and provide these documents electronically for posting on the County’s website.
	10. Contractor should assist the County with: Creating County specific enrollment and educational material and attending on-site enrollment meetings (typically 4 onsite sessions are held). Meetings can be held virtually at the County’s discretion.
	11. Contractor agrees to accept the County’s benefits enrollment files electronically on an ongoing basis from the County’s online enrollment vendor, currently BenefitFocus.
	12. Contractor shall be the claims fiduciary and accept fiduciary responsibility for claims payment decisions and for defense of actions taken for claims adjudicated and related appeals, including the legal defense of claims determinations and medical and pharmacy clinical decisions. The County will be responsible for the legal defense of claims for which the County made the choice as to the determination of coverage. The Contractor shall be responsible for the legal defense of claims that involve the claim determination based on the Contractor’s medical, pharmacy, and authorization standards. The County shall be informed of appeals and Contractor decisions on appeals but is not to be responsible for any claim’s determination matters or appeals.
	13. Contractor will have contractual arrangements in place with external claims review companies that will be made available to the County’s members. Proposer will be responsible for facilitating all aspects of the external review process and will provide the external review company with the claims and plan information needed for an appropriate determination to be made.
	14. Contractor shall process and adjudicate all medical and prescription drug claims in accordance with the health plan document. Contractors will be held liable for claims adjudicated outside of the terms and conditions of the health plan document.
	15. Contractor should have the ability to identify claims that could potentially be subject to third party liability such as workers compensation, auto accident, and coordination of benefits, and act on the claims using the same standards in place for the Contractor’s fully insured health plan clients.
	16. Contractor shall adhere to standards of care by agreeing to use the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent claims administrator/fiduciary acting in a like capacity, and familiar with such matters, would use under similar circumstances as the standard of care for medical and pharmacy services.
	17. Contractor will work in collaboration with the County and its employee health clinic provider, currently Everside Health, to assimilate data, report outcomes, and plan strategies to improve health and manage costs.
	18. Annual member satisfaction surveys, specific to the County, shall be conducted.
3. **PLAN DESIGN AND NETWORK SERVICES**
	1. Proposals for the medical plans are to include an open-access (non- Gatekeeper) model option. A referral should not be required for access to an In-Network; however certain services may require prior authorization.
	2. Proposals are to include health plan options and administration that closely match the current health plans as outlined in Exhibit K – Plan Documents.
	3. Contractor should have discount arrangements for complementary and alternative medicine services for plan members.
	4. Contractor shall track End Stage Renal Disease member eligibility toward Medicare entitlement to outreach to impacted members and assist in applying for Medicare benefits. Contractor shall process claims as Secondary at the end of the applicable Medicare Coordination Period.
	5. Contractor shall complete the Medical Network Participation Worksheet (Attachment 4) and Pharmacy Network, Formulary, and Cost Guarantees Worksheet (Attachment 5) included with this RFP. In addition, network hospitals and physicians designated as a high performing provider, meeting your provider established cost and quality of care guidelines, are to be listed in the appropriate column.
	6. Contractor shall include a comprehensive regional network of hospitals, outpatient facilities, physicians, other covered healthcare providers, and pharmacies, specifically in Lake, Marion, Orange, Polk, Seminole, Sumter, and Volusia Counties.
	7. The regional networks should have 85% of providers Board Certified/Board Eligible, and an annual turnover rate of less than 3%.
	8. Contractor shall include a comprehensive statewide and national network of hospitals, outpatient facilities, physicians, other covered healthcare providers, and pharmacies.
	9. In addition to a network of retail pharmacies, Contractor should include mail order and specialty pharmacy services.
	10. Contractor network shall include state and national access for non-emergency and emergency care, including services provided at Centers of Excellence.
	11. Contractor network shall include coverage for international emergency care.
	12. Contractor shall specify contracted services where capitation is applied. Contractor shall provide detailed encounter data for services covered under capitated arrangements.
	13. Contractor shall hold members harmless from balance billing when using in -network providers, when being referred for specialty services by an in-network provider, and for services provided by an in-network provider that are not approved by the Contractor in accordance with the No Surprises Act and Transparency in Coverage Rule. Contractor shall monitor regional network performance based on nationally recognized quality standards and act with network providers when standards are not being met.
	14. County may have an interest in a Patient Centered Medical Home (PCMH) model at a future date and is interested in the Contractor’s current capability to provide the service and the regional network of providers currently under contract for the PCMH.
	15. Contractor shall allow the County’s onsite clinic providers to be designated as a primary care provider within their system.
	16. Value Based Contracting Arrangements shall be based on written evidenced-based criteria conveyed to the County with the financial element based solely on the service improvements and results that can be tied directly to the County’s plan membership. The County desires to hold any possible performance incentive payments in escrow until the payment is due to the providers. Any such payment shall be transparent, and a complete audit tracking shall be available to the County.
	17. Contractor shall provide telemedicine services for members including urgent and convenience care type of medical care and behavioral health.
	18. Contractor shall provide telemedicine services for members who are established patients of primary care network providers for services such as follow up care, known condition specific care, and maintenance medication refills.
4. **HEALTH MANAGEMENT**
	1. Contractor shall include an online health risk assessment (HRA) tool, accessible to members, capable of having biometric screening results loaded into an individual’s HRA and will provide an aggregate report to the County on the responses, including the changes in risk factors.
	2. Contractor shall include onsite biometric screenings and health coaching for members at convenient times and at a minimum of 7 locations each year.
	3. Contractor shall track adherence for preventive care guidelines and agree to take action to increase preventive care utilization.
	4. County desires to have an experienced case management team assigned to the County to address the specific needs of seriously ill plan members.
	5. Disease management programs are to be provided and are to have demonstrated success in participation, and care outcomes.
	6. Contractor shall assist the County with customized, targeted initiatives to improve the health of the population. Comprehensive initiatives may include voluntary programs for:
		1. Weight management for healthy weight, overweight, obese, or morbidly obese members.
		2. Muscular skeletal
		3. Diabetes control and prevention;
		4. Tobacco cessation;
		5. Comprehensive cardiology program, including hypertension control and prevention.
		6. Oncology management program;
		7. Healthy pregnancy;
		8. Compliance with preventive screening guidelines; and
		9. Nutritional education for adults.
	7. Contractor shall be able to process onsite immunizations, such as flu shots, as a medical claim from the County’s selected vendor.
	8. Contractor shall have the capability to administer co-payment incentives specifically for members participating in and adhering to the qualifications of health and wellness activities and County targeted initiative programs.
	9. Contractor shall have an established comprehensive Fraud, Waste and Abuse (FWA) policy that will be integrated in the County plans.
	10. Contractor shall include a Wellness Fund of an annual minimum of $25,000 for each year of the contract term, to be used at the discretion of the County to help support their health management initiatives.
5. **FINANCIAL SERVICES, REPORTING, AND DATA INTERFACE**
	1. The finance and banking arrangements for the self-funded health plan shall include documentation for claims reimbursement and shall meet the accounting and payment needs of the County, as determined by the County.
	2. County shall pay for applicable administrative fees in the month the services are incurred and pay the medical and pharmacy claims monthly following the month the claims are processed and paid, via ACH wire transfer.
	3. Contractor shall accept self-billing by the County for administrative fees which is based on the eligibility provided.
	4. Contractor shall have the capability to integrate laboratory and biometric screening results, specific to each member and performed for the Contractor and by an independent screening company approved by the Contractor, into the utilization history of each member.
	5. Contractor shall provide eligibility reporting, eligibility discrepancy reports, and benefit administrative reports, designed to meet the administrative needs of the County, that will be available to the County on a daily, weekly, monthly, quarterly or annual basis.
	6. Contractor shall provide comprehensive medical and pharmacy claims and eligibility file downloads (data dumps), in a HIPAA compliant, standard industry format, to the County benefits consultant on a monthly basis. Monthly claims detail should include, at minimum, all fields listed in Claims File Layout, Exhibit G.
	7. Contractor shall provide the County’s Flexible Spending Account vendor, currently WEX, a debit card substantiation file, in a mutually agreeable format.
	8. Contractor shall provide to the County’s stop loss insurance carrier monthly reports on large claimants, to include the data fields needed by the insurance carrier to administer the County’s stop loss insurance policy, and timely provide such information to stop loss provider information required for stop loss provider to process claims.
	9. Contractor’s books and records, together with the supporting or underlying documents and materials shall be made available, upon request, to the County, through its employees, agents, representatives, contractors or other designees, during normal business hours at Contractor’s office or place of business in Orlando, Florida. In the event that no such location is available, then the books and records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location in Orlando, Florida, which is convenient for the County. This paragraph shall not be construed to limit, revoke, or abridge any other rights, powers, or obligations relating to audit which the County may have by state, city, or federal statute, ordinance, regulation, or agreement, whether those rights, powers, or obligations are express or implied.
	10. Contractor shall allow an annual risk-based or focused audit. The scope of such focused audit may include payment documents related to a focused, targeted or risk-based review of a sample of claims of not more than 400 claims paid during the two prior plan years and not previously audited. The focused audit may include claims prone to overpayments or other errors without regard to claims prone to underpayments.
6. **PHARMACY SERVICES**
	1. Contractor of pharmacy services shall include $0 administrative fees.
	2. Contractor shall confirm the following as it relates to the pharmacy program pricing and guarantees:
		1. Contractor will utilize a broad network of pharmacies for pricing guarantees that will include the major chain pharmacies as In Network.
		2. Contractor will use the broadest formulary for pricing guarantees with no Brand and Specialty exclusions.
		3. Single-Source Generic prescriptions, Multiple-Source generic prescriptions, MAC and Non-MAC generic prescriptions will be included in the generic medication category for discount and fill rate guarantee calculations.
		4. Brand drug. The term brand drug shall mean the following: The multisource code field in Medi-Span that contains an “M” (co-branded product), “O” (originator brand), or an “N” (single source brand); however, if the Multisource Code is “O” and there is a DAW Code of 3, 4, 5, 6, or 9, the drug shall be considered a generic drug.
		5. Generic drug. The term generic drug shall mean the following: The multisource code field in Medi-Span that contains a “Y” (generic). An item shall also be considered a generic drug if the Multisource Code is “O” and there is a DAW code of 3, 4, 5, 6, or 9. The parties agree that when a drug is identified as a generic drug, it shall be considered a generic drug for all purposes under this agreement. A Single Source generic drug shall also be considered a Generic drug.
		6. Single-Source Generics will be identified as medications having one manufacturer during the six-month exclusivity period.
		7. Usual and Customary (U & C) Claims, Zero Balance Claims, Compounds and Over-the-Counter claims will be excluded for discount and fill rate guarantee calculations.
		8. “Ingredient Cost” will mean the lesser of MAC price, discounted AWP or the dispensing pharmacy’s U & C.
		9. Contractor shall utilize the timeliest, expansive, and cost-effective MAC list on behalf of the County.
		10. Plan members will always be charged the lesser of their plan copayment, the PBM’s contracted price, the pharmacy U&C, or the cash price.
		11. Contractor shall base AWP (Average Wholesale Price) on date sensitive, 11-digit National Drug Code (NDC) of the actual product dispensed as supplied by Medi - Span for retail, mail order, and specialty adjudicated claims with no repackage fee applied.
		12. Proposed discount guarantees and other guarantees will be the minimum guarantees (not fixed) regardless of whether the County implements any additional specific clinical management programs such as step therapies or prior authorizations.
		13. Rebate guarantees shall be based on each brand medication dispensed.
		14. Rebate revenue that is earned by the County during the term of the agreement with the Contractor will be paid to the County at least quarterly and will be paid following termination of the agreement, as long as claims reimbursements remain current.
		15. Contract shall pass through 100% of the rebates received.
		16. Auditing of all pharmacy claims will be permitted versus a claims sample.
		17. Pricing guarantees being measured and reconciled shall be categorized in the following distinct components:
			1. Retail and mail order generic and brand medications;
			2. Specialty medications;
			3. rebates; and
			4. generic fill rate
		18. No surpluses in one guarantee component shall be used to offset deficits in another component.
		19. Guarantee shortfalls will be guaranteed on a dollar-for-dollar basis with 100% of any shortfall in any component recouped by the County.
		20. Specialty Drugs are defined as FDA approved prescription drugs that require special handling, storage, training, distribution, and management of therapy. The list of Specialty Drugs meeting this definition will be made available to the County upon implementation of the Contract and will be updated as drugs are included and excluded.
		21. Guaranteed specialty medication discounts shall be based on an aggregate specialty discount and shall include all specialty medications dispensed that have been approved by the Contractor’s Pharmacy Drug Review Committee.
	3. Contractor shall commit to minimum discount and cost guarantees on retail and mail order generic and brand medications, specialty medications, and rebates for a minimum of three (3) years.
	4. Contractor shall commit to implementing a retail 90 day generic and brand fill program.
	5. Contractor shall commit to minimum generic dispensing fill rate guarantees for a minimum of three (3) years.
	6. Contractor shall notify impacted members of negative formulary changes, along with cost effective alternative(s), that may occur annually and throughout the plan year as applicable.
	7. Contractor shall continue the County’s current step therapy and clinical prior authorization programs.
	8. Open mail order transfer files and prior authorization files for pharmacy shall be provided upon termination without additional fee.
	9. Contractor shall include monthly pharmacy claims and eligibility file downloads (data dumps), in a HIPAA compliant, standard industry format, shall be provided to the County’s benefits consultant on a monthly basis. Monthly claims detail should include, at minimum, all fields listed in Claims File Layout. Claims File Layout can be found on Exhibit G.
7. **COST OF SERVICES AND PERFORMANCE GUARANTEES**
	1. The Administrative Services Only (ASO) fees proposed shall be deemed to be inclusive of all of the services proposed unless otherwise expressly stated. Other services as outlined in the Scope of Services not included in your ASO fees shall be specified in detail.
	2. The following SHALL BE guaranteed for ASO proposals for plan years 2024-2025, 2025-2026 and 2026-2027 (2027-2028 and 2028-2029 are optional guarantees):
		1. Administrative fees
		2. Minimum medical discount guarantees
		3. Pharmacy pricing guarantees
		4. Generic fill rate guarantees
	3. Contractors are to clearly disclose any retained fees (shared savings) for all programs such as subrogation, out-of-network fee negotiations, overpayment recoveries, etc.
	4. Contractor shall include minimum network discount guarantees, with no corridor, for a minimum of three (3) plan years.
	5. Performance Guarantees and associated penalties should be proposed and include but not be limited to the following categories:
		1. Implementation
			1. Plans loaded and tested; staff trained; eligibility accurate and ID cards issued before 10/1/2024.
			2. Contract negotiations completed by May 31, 2024
			3. Summary of Benefits and Coverage (SBC) completed by August 1, 2024
			4. Banking arrangements completed by September 1, 2024
			5. SPD plan documents received by September 1, 2024
		2. Summary of Benefits and Coverage (SBC) completed by August 1st of each year.
		3. SPD plan documents received by September 1st of each year.
		4. Network stability should include an annual turnover of 3% or less in Lake, Marion, Orange, Polk, Seminole, Sumter, and Volusia Counties.
		5. Administration standards should be County specific and shall include:
			1. Financial Accuracy to be calculated by using total claims dollars processed, compared to the combined over and under payment errors, with a minimum of 99% accuracy.
			2. Processing Accuracy of at least 99% of the total number of correct claims divided by the total claims processed.
			3. Turnaround Time minimum of 94% clean claims in 14 calendar days and 100% all clean claims in 30 days.
		6. Accurate and Timely Reporting with Monthly, Quarterly and Annual reporting due by the 20th of the following month.
		7. Account Management standards that demonstrate the Proposer’s commitment to maintain experienced, dedicated account service contacts that provide ongoing and timely service to the County’s administrative staff, conduct service meetings with the County to review the status of the account and services deliverable, and issue resolution as needed.
		8. Customer Service standards that will include average speed to answer, and call abandonment rates.

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