LOCEY & CAHILL, LLC

AN *INDEPENDENT* CONSULTING FIRM

Prescription Benefit Manager Request for Proposal (RFP)

PRESENTED ON BEHALF OF:

GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

LOCEY & CAHILL, LLC
120 WALTON STREET, SUITE 500
ARMORY SQUARE
SYRACUSE, NY 13202-1138
TEL 315-425-1424
FAX 315-425-1394
WWW.LOCEYCAHILL.COM

RFP Response Due Date: Friday, September 23, 2011

LOCEY & CAHILL, LLC

GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

Prescription Benefit Manager Request for Proposal (RFP)

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Section I

INTRODUCTION

INTRODUCTION

The Greater Tompkins County Municipal Health Insurance Consortium is requesting proposals from prescription benefit managers for a self- insured prescription drug program. The proposed start date for this plan is January 1, 2012.

The Greater Tompkins County Municipal Health Insurance Consortium is an organization made up of the following municipalities:

City of Ithaca	County of Tompkins	Town of Caroline
Town of Danby	Town of Dryden	Town of Enfield
Town of Groton	Town of Ithaca	Town of Ulysses
Village of Cayuga Heights	Village of Dryden	Village of Groton
Village of Trumansburg		

As can be noted from the above list, all of the Municipal Corporations lie within the geographical and political boundaries of Tompkins County, New York.

The Greater Tompkins County Municipal Health Insurance Consortium, currently covers approximately 2,300 employees and based on the different municipalities and each members' collective bargaining agreement, offers employees, retirees and their families a prescription benefit plan which contains a variety of modest co-payments for retail prescription drugs and mail order prescription drugs purchased by covered members.

The Greater Tompkins County Municipal Health Insurance Consortium wishes to receive proposals for a full array of prescription benefit management services for both the retail and mail order programs. The selected bidder will have to provide the Greater Tompkins County Municipal Health Insurance Consortium with an agreement which complies with the provisions set forth in Article 47 of New York State Insurance Law and all other applicable Federal and State Laws and Regulations. The Consortium will entertain proposals for an integrated retail, mail order and specialty prescription benefit management services only on a self insured basis.

Due to the costs associated with providing this particular benefit, the Consortium has placed significant importance on the reimbursement rates paid by each PBM to pharmacies for covered medications. The Consortium requests that all proposals be quoted utilizing a "transparent pricing" model. *This means that the chosen provider will not retain any money associated with prescription drug rebates or any money associated with the margin between guaranteed reimbursement rates and the actual amount paid to the pharmacies*. The Consortium will reimburse covered medications on a dollar for dollar basis, receive all pharmaceutical rebates in full, and will pay the chosen administrator a fixed dollar amount calculated either on a per member or on a per claim basis. If your organization does not provide a "transparent pricing" model and you still wish to submit a proposal, you must clearly identify this in your cover letter and in your proposal.

Currently, the Greater Tompkins County Municipal Health Insurance Consortium has eight (8) co-payment plans available for their plan participants of which three (3) are a traditional two-tier option and eight (8) are a three-tier formulary based option. Please refer to the summary below for a synopsis of these benefit options. It should be noted that additional copayment options may be requested at a future time.

Please note that the "**" indicates these are benefits currently offered.

Two Tier Plans

Retail Pharmacy (30-Days or 104 Doses)		Mail-Order (90-Days Supply)	
Generic	Brand Name	Generic	Brand Name
$1.00**	1.00	$0.00	$0.00
$2.00**	$5.00	$0.00	$0.00
$2.00**	$10.00	$0.00	$0.00

Three Tier Plans

Retail Pharmacy (30-Day Supply)			Mail-Order (90-Day Supply)		
Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
$5.00**	$10.00	$25.00	$10.00	$20.00	$50.00
$5.00**	$10.00	$25.00	$5.00	$10.00	$25.00
$5.00**	$15.00	$25.00	$10.00	$30.00	$50.00
$5.00**	$15.00	$25.00	$10.00	$30.00	$60.00
$5.00**	$20.00	$35.00	$10.00	$40.00	$70.00
$10.00**	$25.00	$40.00	$20.00	$50.00	$80.00
20%**	30%	50%	20%	30%	50%
20%**	20%	40%	15%	15%	40%

As will be identified later in this RFP, it is imperative that the selected administrator offer a program that is Equal To or Better Than the current program through both the benefits and the network access offered to the Plan's Enrollees. The Greater Tompkins County Municipal Health Insurance Consortium will play an integral part in the evaluation phase of this RFP Process.

CURRENT COVERAGE PARAMETERS

The current program in place is a traditional retail/ mail order program, and the program has been self-funded for the past nineteen years.

Due to the labor agreements in place with the various associations, it is mandatory that any proposals submitted as part of this process offer benefits that are "Equal To or Better Than" those that are currently in place.

QUOTATION OPTIONS

The Greater Tompkins County Municipal Health Insurance Consortium is interested in receiving proposals from companies which have experience working with large municipal organizations in the State of New York. In addition, your proposal must offer a plan design that meets the "Equal to or Better Than" criteria for both the benefits offered as well as the pharmacy network that enrollees have access to for in-network benefits. No other proposals will be accepted as part of this process.

At this time, the Consortium has retained Locey & Cahill, LLC to assist them in obtaining the necessary information to select a qualified prescription benefit manager. The chosen administrator will have the opportunity to:

Administer a large group medical plan of approximately 2,300 contracts covering approximately 5,000 covered lives (employees, dependents, and retirees);

Be an integral part of a high quality medical benefits plan; and

Develop a mutually beneficial relationship with a large municipal employer in New York State.

SELECTION CRITERIA

The Greater Tompkins Municipal Health Insurance Consortium's selection of a prescription benefit manager will be based on a number of critical areas (the following list is not necessarily ranked in any specific order):

1. Administrative Fees (including dispensing fees);
2. Administrative Support (e.g., report generation, membership, and client support);
3. Contract Terms and Conditions (Minimum Premium Insured Contract);
4. Compliance with State and Federal Laws and Regulations;
5. Customer Service Capabilities;
6. Transparent based and Prescription Drug Pricing and Rebate Arrangements;
7. Plan Design (Ability to provide equal to or better benefits);
8. Pharmacy Network Size and Location (Local and National);
9. References.

The selection of a prescription benefit manager will be based upon each organization's abilities and capabilities as identified by the submitted proposals. Your response should follow each of the questions identified in the Request for Information (Section IV), repeating each question prior to giving your answer. Your responses should be direct and brief.

At the Greater Tompkins Municipal Health Insurance Consortium's request, an on-site review may also be conducted to better assess finalist's capabilities and limitations.

All questions regarding this RFP should be directed in writing to Mr. Stephen Locey, President, Locey & Cahill, LLC at the following address:

Locey & Cahill, LLC
120 Walton Street, Suite 500
Syracuse, NY 13202
(315) 425-1424
slocey@loceycahill.com

All questions about the meaning or intent of the specifications must be submitted to the aforementioned designated person in writing. Replies will be issued by an Addenda mailed or delivered to all parties recorded as having received the proposal documents. Questions received less than four (days) prior to the required date of submission for Proposals will not be answered. Only questions answered by formal written Addenda will be binding.

ADMINISTRATOR SELECTION AND IMPLEMENTATION TIME-TABLE

TASK	DATE	Sep	Oct	Nov	Dec	Jan
1. Distribution of Request for Proposal (RFP)	09/02/11	Y				
2. RFP Response Deadline *Friday September 23rd at 4:00 p.m.)*	09/23/2011	Y				
3. Responses Evaluated	09/26-10/7/11	Y	Y			
4. On-Site Visits with the finalists (if applicable)	10/10 – 10/14/11		Y			
5. Final Provider Selection Process	10/17 – 10/31/11		Y			
6. Final Provider Selection	10/31/11		Y			
7. Implementation	11/1 - 12/31/11			Y	Y	
8. Effective Date	01/01/12					Y

Section II

RFP Information

Greater Tompkins County Municipal Health Insurance Consortium

REQUEST FOR PROPOSALS
PRESCRIPTION BENEFIT MANAGEMENT (PBM) SERVICES

ARTICLE 1: PURPOSE

1.1 The Greater Tompkins County Municipal Health Insurance Consortium is seeking proposals from Prescription Benefit Managers (PBMs) to administer the Consortium's prescription drug benefit plan.

ARTICLE 2: RECEIPT OF PROPOSALS

2.1 Four (4) copies of the proposal and other required documents must be delivered, marked with the name and number of the Proposal and the name and address of the PBM and must be received no later than ***September 23, 2011 at 4:00 p.m.*** at the following address:

Mr. Stephen Locey, President, CEO
Locey & Cahill, LLC
120 Walton Street, Suite 500
Armory Square
Syracuse, NY 13202-1138
Tel. (315) 425-1424

2.2 The proposal submitted by the individual PBM(s) is the document upon which the Greater Tompkins County Municipal Health Insurance Consortium will make its initial judgment regarding the PBM's understanding of the Consortium's scope and objectives, qualifications, methodology, and ability to complete services under the contract.

2.3 Those submitting Proposals do so entirely at their expense. There is no express or implied obligation by Greater Tompkins County Municipal Health Insurance Consortium to reimburse any firm or individual for any costs incurred in preparing or submitting Proposals, preparing or submitting additional information requested by the Greater Tompkins County Municipal Health Insurance Consortium, or for participating in any selection interviews.

2.4 Submission of any Proposal indicates acceptance of the conditions contained in the RFP, unless clearly and specifically noted otherwise in the Proposal.

2.5 The Greater Tompkins County Municipal Health Insurance Consortium reserves the right to reject any and all Proposals, in whole or in part, submitted in response to its RFP.

2.6 The Greater Tompkins County Municipal Health Insurance Consortium reserves the right to waive any and all informalities and to disregard all non-conforming, non-responsive or conditional Proposals.

2.7 The Greater Tompkins County Municipal Health Insurance Consortium may, at any time by written notification to all PBMs, change any portion of the RFP described and detailed herein.

2.8 Proposals will be examined and evaluated by the Greater Tompkins County Municipal Health Insurance Consortium and Locey & Cahill, LLC.

2.9 During the evaluation of Proposals, the Greater Tompkins County Municipal Health Insurance Consortium may require clarification of information or may invite PBMs to an oral presentation to amplify and/or validate Proposal contents.

ARTICLE 3: QUALIFICATION OF PBM:

Provide a statement of PBM qualifications including:

3.1 Provide the name, a brief history and description of your firm, including your firm's most recent annual report.

3.2 Identify your firm's professional staff members who would be involved in the Greater Tompkins County Municipal Health Insurance Consortium engagement and the experience each possesses and the location of the office from which each works.

3.3 Name and title of person(s) authorized to bind the PBM, together with the main office address, telephone number (including area code), fax number, and e-mail address.

3.4 Detail your firm's experience, including a description of your firm's experience working with municipal clientele similar to the Greater Tompkins County Municipal Health Insurance Consortium.

3.5 Describe any legal or contractual relationships your firm has with any pharmaceutical companies.

3.6 Provide full disclosure relative to any government investigations, indictments, and/or convictions your firm has experienced relative to proven or suspected violations of the Laws of the State of New York and/or the United States of America.

3.7 Provide at least five (5) references from similar projects including name, addresses and telephone numbers.

3.8 Provide any additional information that would distinguish your firm in its services to the Greater Tompkins County Municipal Health Insurance Consortium (e.g., electronic billing, on-line membership management, detailed reporting, etc.).

3.9 In addition, the Greater Tompkins County Municipal Health Insurance Consortium may make such investigations it deems necessary to determine the ability of the PBM to perform the work. The PBM shall furnish to the Greater Tompkins County Municipal Health Insurance Consortium, within five (5) days of a request, all such information and data for this purpose as be requested. The Consortium reserves the right to reject any Proposal if the information submitted by, or investigation of, such PBM fails to satisfy the Consortium that such PBM is properly qualified to carry out the obligation of the contract and to complete the work contemplated therein. Conditional Proposals will not be accepted.

ARTICLE 4: TERM OF CONTRACT:

4.1 The initial contract period shall be January 1, 2012 through December 31, 2012 with the option to continue the contract thereafter for successive one year terms as determined by the Greater Tompkins County Municipal Health Insurance Consortium.

4.2 The successful PBM shall execute a contract with the Greater Tompkins County Municipal Health Insurance Consortium in substantial conformance with this RFP.

ARTICLE 5: COST PROPOSAL:

5.1 Submit a cost proposal for the services described on the Cost Proposal Form included herein.

5.2 Provide any other relevant information that will assist the Greater Tompkins County Municipal Health Insurance Consortium in evaluating your Proposal.

5.3 Quoted Fees - **A 3-year rate guarantee for administrative services is being sought**. If formulas, such as inflationary escalators are stated as part of the guarantee, a maximum rate should be guaranteed. Please confirm this guarantee in your response to the RFP and note any additional guarantees your organization may wish to extend the Greater Tompkins County Municipal Health Insurance Consortium. Any and all fees and/or reimbursements that may be paid by the Consortium must be identified in Section VI, Article VII of the Request for Information Section of this RFP. All the information contained in that section will be considered as your organization's full proposal and the Greater Tompkins County Municipal Health

Insurance Consortium will not make any future payments to your organizations if they are not clearly identified and quoted in this section. Any projections that you wish to submit with your proposal should be included as an addendum to the Request for Information Response. If you submit claims projections, you should clearly explain the actuarial assumptions that are being used to make such projections.

ARTICLE 6: RIGHT TO AUDIT:

6.1 The Greater Tompkins County Municipal Health Insurance Consortium Reserves the right to audit the claim records and other records of the selected carrier, as they pertain to the Prescription Drug Program. The Greater Tompkins County Municipal Health Insurance Consortium also reserves the right to assign outside auditors and to conduct on-site audits of any selected organization's records and files. Said audits will be conducted at the discretion of the Greater Tompkins County Municipal Health Insurance Consortium. The Consortium shall provide reasonable notice regarding said audits and the audits will be conducted at the carrier's office during normal business hours.

6.2 The selected carrier may not charge extra fees for providing data tape(s) or for space and equipment utilized by outside auditors. Upon completion of the audits, the selected carrier's representatives should make themselves available to the Greater Tompkins County Municipal Health Insurance Consortium in order to resolve any deficiencies and shortcomings of the selected carrier's services.

ARTICLE 7: CONFIDENTIALITY:

7.1 To protect the confidentiality of the information contained in this RFP, you will agree not to disclose any information to any parties inside your organization, other than those with a need to know. You are prohibited from disclosing any information contained in this RFP to any parties outside of your organization without the express, written authorization of the Greater Tompkins County Municipal Health Insurance Consortium

ARTICLE 8: TRADE SECRET AGREEMENT:

8.1 The selected vendor(s)/carrier(s) may be required to sign a "Trade Secret Agreement" which protects all data furnished by the Greater Tompkins County Municipal Health Insurance Consortium and/or its agents (representatives).

ARTICLE 9: PROPOSAL SUBMISSION:

9.1 In order for the Greater Tompkins County Municipal Health Insurance Consortium to conduct a uniform review process of all proposals, proposals must be submitted in the format set forth below. Failure to follow this format may be cause for rejection of a proposal because adherence to this format is critical for the evaluation process:

SECTION I:

Title Page - The Title Page should reflect the Request for Proposal subject, name of the PBM, address, telephone number and contact person.

Table of Contents -The Table of Contents must indicate the material included in the proposal by section and page number.

SECTION II:

Qualifications / Experience - The Qualification / Experience Section must address PBM's qualifications and experience to carry out the requested services, inclusive of, but not limited to: qualifications to do business in New York State, number of years in business and length of experience.

Resumes -Resumes of professional staff members who may be involved in the Greater Tompkins County Municipal Health Insurance Consortium engagement must be included in this section.

SECTION III:

Prescription Benefit Manager Request for Information - This section of your response should include the completed questionnaire found in Section IV of this RFP.

SECTION IV:

Plan Implementation - The Plan Implementation Section must address the Scope of Services in terms of the PBM's plan to carry out the requested service. This section must include a detailed transition plan outlining the steps necessary for an uneventful and seamless implementation of your company's proposed plan.

SECTION V:

Cost Proposal Section - The Cost Proposal Section must include all costs associated with the PBM's plan to carry out the requested service. Any cost proposal forms furnished by the Greater Tompkins County Municipal Health Insurance Consortium must be included in this section.

SECTION VI:

References - The References Section must include references from similar type municipal clients.

ARTICLE 10: PROPOSAL EVALUATION:

10.1 Proposals will remain valid until the execution of a contract by the Greater Tompkins County Municipal Health Insurance Consortium, unless otherwise rejected consistent with this RFP.

10.2 All proposals must contain a detailed transition plan outlining the steps to be taken to steps to assure a smooth and orderly implementation of your company's proposed plan.

10.3 Proposals received will be evaluated and scored by the Greater Tompkins County Municipal Health Insurance Consortium and Locey & Cahill, LLC. Proposals shall be evaluated based upon set criteria. Each criterion is weighted, based on a scale of 1 - 5, with higher weight indicating greater importance of criterion.

10.4 Criteria will be rated on a scale of 1 - 10, with higher scores indicating greater degree of approval by the Evaluation Team. A rating will be assessed by the Greater Tompkins County Municipal Health Insurance Consortium and Locey & Cahill, LLC for each criterion for each proposal.

10.5 The Evaluation Process is designed to award the proposal not necessarily to the PBM of least costs, but rather to the PBM with the best combination of attributes based on the Evaluation Criteria. A score shall be calculated for each criterion for each proposal. The score shall be the product of the rating assessed by the Evaluation Team for any given criterion, multiplied by the pre-established weight for that criterion. The total of the scores for all criteria in each proposal will be known as the PBM's final score.

10.6 Criteria and weights are as follows:

CRITERIA	WEIGHT (1 - 5)
1. Transparent Based Prescription Drug Pricing	5
2. Rebate Arrangements	5
3. PBM Administrative Fees	5
4. Contract Terms and Conditions (Minimum Premium Based Contract);	5
5. Pharmacy Network Size and Location (Local and National);	4
6. Customer Service Capabilities:	3
7. References.	3
8. Administrative Support (e.g., report generation, membership, and client support);	2
9. Compliance with State and Federal Laws and Regulations;	1

10.7 Proposals will be examined and evaluated by Locey & Cahill, LLC to determine whether the requirements of this RFP are met and to make a recommendation to the Greater Tompkins County Municipal Health Insurance Consortium

ARTICLE 11: ALTERNATIVES:

11.1 The PBM may include in its Proposal items not specified in this RFP which it would consider pertinent. All such alternatives must be listed separately from the Proposal and the cost thereof must be separate and itemized.

ARTICLE 12: INDEMNIFICATION:

12.1 The successful PBM shall defend, indemnify and hold harmless the Greater Tompkins County Municipal Health Insurance Consortium and it's employees, Locey & Cahill LLC and their agents, officers and associates, from and against all claims, damage, losses and expenses (including without limitations, reasonable attorneys' fees) arising out of, or in consequence of, any negligent or intentional act or omission of the successful PBM, its employees or agents, to the extent of its or their responsibility for such claims, damages, losses and expenses.

ARTICLE 13: SPECIFICATION CLARIFICATION:

13.1 All inquires with respect to this Request for Proposal must be directed, in writing , to Mr. Stephen Locey as follows:

Mr. Stephen Locey, President, CEO
Locey & Cahill, LLC
120 Walton Street, Suite 500
Syracuse, NY 13202-1138
Tel. 315- 425-1424
Fax 315-425-1424

13.2 All questions about the meaning or intent of the specifications must be submitted to the aforementioned designated person in writing. Replies will be issued by an Addenda mailed or delivered to all parties recorded as having received the proposal documents. Questions received less than four (days) prior to the required date of submission of Proposals will not be answered. Only questions answered by formal written Addenda will be binding.

ARTICLE 14: MODIFICATION AND WITHDRAWAL OF PROPOSALS:

14.1 Proposals may be modified or withdrawn at any time prior to the opening of Proposals by an appropriate document duly executed (in the manner that a Proposal must be executed) and delivered to the place where Proposals are to be submitted.

14.2 If within twenty-four (24) hours after the proposals are opened, any PBM who files a duly signed written notice with Locey & Cahill, LLC and promptly thereafter demonstrates to the reasonable satisfaction of Locey & Cahill, LLC that there was a material and substantial mistake in the preparation of its Proposal, that PBM may withdraw its Proposal and the Proposal Security will be returned. Thereafter, that PBM will be disqualified from making a further or additional proposal on the work contemplated by this RFP.

14.3 Each Proposal shall state that it is a firm offer for a period of ninety (90) days from the Proposal opening date. After expiration of the firm offer period, if no contract award has been made, a Proposal may be withdrawn if the PBM does so in writing directed to Locey & Cahill, otherwise, Proposals remain in effect consistent with the terms of this RFP.

ARTICLE 15: PROPOSAL SECURITY:

15.1 No Proposal Security is requested for this Proposal.

ARTICLE 16: INSURANCE AND SECURITY REQUIREMENTS:

16.1 The successful PBM will be required to produce and maintain, at its own expense, the following insurance coverage:

(a) **Workers' Compensation and Employer's Liability Insurance:** A policy or policies providing protection for employees in the event of job related injuries.

(b) **General Liability Insurance:** A policy or policies or comprehensive all-risk insurance with limits of not less than:

Liability For:	Combined Single Limit
Property Damage	$1,000,000
Bodily Injury	$1,000,000
Personal Injury	$1,000,000

16.2 Each policy of insurance required shall be of form and content satisfactory to the Greater Tompkins County Municipal Health Insurance Consortium's Attorney:

(a) The Greater Tompkins County Municipal Health Insurance Consortium shall be named as an additional named insured.

(b) The policy shall not be changed or canceled until the expiration of thirty (30) days after written notice to the Greater Tompkins County Municipal Health Insurance Consortium. It shall be automatically renewed upon expiration and continued in force unless the Greater Tompkins County Municipal Health Insurance Consortium is given at least thirty (30) days written notice to the contrary.

ARTICLE 17: CASH DISCOUNT:

17.1 Cash discounts may be offered by a PBM for prompt payment of bills, but such cash discounts will not be taken into consideration in determining the low PBM.

17.2 For purposes of any applicable cash discount, the payment date shall be calculated from the receipt of invoice or final acceptance of the goods, whichever is later.

ARTICLE 18: FREEDOM OF INFORMATION LAW:

18.1 The New York State Freedom of Information Law as set forth in Public Officers Law, Article 6, Section 84-90, mandates public access to government records, however, proposals submitted in response to this RFP may contain technical, financial background or other data, of which public disclosure could cause substantial injury to the PBM's competitive position or constitute a trade secret. PBMs who have a good faith belief that the information submitted in their proposals is protected from disclosure under the New York Freedom of Information Law must clearly identify the pages of the proposals containing such information by typing in bold face on the top of each page, "**THE PBM BELIEVES THAT THIS INFORMATION IS PROTECTED FROM DISCLOSURE UNDER THE STATE FREEDOM OF INFORMATION LAW**". The Greater Tompkins County Municipal Health Insurance Consortium assumes no liability for disclosure of information so identified, provided that the Consortium has made a good faith legal determination that the information is not protected under applicable law or where disclosure is required to comply with an order or judgment of a court of competent jurisdiction.

STATEMENT OF COMPLIANCE:

Please submit as a part of your proposal the following information:

RE: Greater Tompkins County Municipal Health Insurance Consortium

We hereby acknowledge receipt of the Prescription Benefit Manager RFP for the Greater Tompkins County Municipal Health Insurance Consortium and verify that our proposal conforms to the RFP except as detailed below:

Company Name:_____

Signature:_____

Print Name:_____

Title:_____

Date:_____/_____/_____

Section III

PRESCRIPTION BENEFIT MANAGER REQUEST FOR INFORMATION

Prescription Benefit Manager Request for Information

RFP RESPONSE: SECTION V

GENERAL INFORMATION:

1. Legal Name of Organization: _____
   DBA Name (if different than above): _____
   Principal location (Administrative Office):_____
   City: _____ State: _____ Zip Code:_____-_____ County: _____
   Tel.#:____-____-_____ Fax #:____-____-_____

   Mail Order Facility :_____
   Address: _____ City: _____ State: _____
   Zip Code:_____-_____ County: _____ Tel.#:____-____-_____ Fax #:____-____-_____

   Specialty Drug Facility:_____
   Address: _____ City: _____ State: _____
   Zip Code:_____-_____ County: _____ Tel.#:____-____-_____ Fax #:____-____-_____

   Account Executive: _____Tel.#:____-____-_____ Fax #:____-____-_____
   Other Key Personnel: _____ Title: _____
   _____ Title: _____

2. Please indicate how this firm is organized (corporation, partnership, LLC, etc...): _____
   What is your state of organization? _____ How long has your organization been in business? _____

3. Federal Tax ID number: ____-_____

4. Does your firm carry Errors & Omissions Insurance and/or Professional Liability Insurance? **YES / NO**
   If yes, please provide Carrier's Name:_____
   Policy Limits:_____ Exp. Date: _____

   Are your employees Bonded? **YES / NO** What Amount? _____

   Address what liability protections are built into the contract you will sign with the Greater Tompkins Municipal Health Insurance Consortium.

   Specifically, what protections does the Greater Tompkins County Municipal Health Insurance Consortium have against negligence and/or malpractice by your organization?

   _____
   _____
   _____

5. Provide copies of all current licenses your organization holds regarding the operation of your business. Provide copies of insurance certificates your organization holds regarding the operation of your business.

ADMINISTRATIVE ISSUES:

6. Included in this RFP is a benefit summary for The Greater Tompkins County Municipal Health Insurance Consortium Prescription Drug Plan; please confirm that this is a benefit structure that your organization can adminster._____
_____

Describe potential problems (if any) associated with the administration of this benefit structure.
_____
_____
_____

7. Describe any reports your organization generates on a monthly, quarterly, annual basis (please provide an example of each). _____
_____
_____

8. Will your organization provide on-line computer access (via modem) to the Greater Tompkins County Municipal Health Insurance Consortium
for the purpose of viewing and updating enrollment and viewing claims data. **YES / NO**

If yes, will eligibility updates be immediately processed into the system? **YES / NO**

9. Are both the retail, mail order and specialty pharmacies, as well as the customer service units, able to access a common database to verify eligibility and benefit administration issues? **YES / NO**

10. Do you understand that The Greater Tompkins County Municipal Health Insurance Consortium (or an authorized agent) reserves the right to audit your organization's administrative processes including the following items?

Data Processing	YES / NO
Claims Processing, including prescription drug reimbursement rates	**YES / NO**
Internal Control Functions	**YES / NO**
Managed Care / Utilization Review Procedures & Results	**YES / NO**
Provider Network Credentialing & Reimbursement Systems	**YES / NO**
Review of Your Firm's Audited Financial Statements	**YES / NO**

11. Do you have a report available that essentially would provide your customers (and their auditors) with an understanding of the flow of transactions and control procedures in your systems? Typically such a report would be in compliance with Statement on Auditing Standard (SAS) No. 70. **YES / NO**

If so, please include a copy with your response to this RFP.

CUSTOMER SERVICE:

12. Provide the following information regarding your organization's customer service functions:

Location of Customer Service Call Center , Mail-Order Facility and Specialty Drug Facility:

Call Center Address: _____ City: _____ State: _____
Zip Code:_____-_____ County: _____ Tel.#:____-____-_____ Fax #:____-____-_____

Mail-Order Address: _____ City: _____ State: _____
Zip Code:_____-_____ County: _____ Tel.#:____-____-_____ Fax #:____-____-_____

Specialty Drug Address: _____ City: _____ State: _____
Zip Code:_____-_____ County: _____ Tel.#:____-____-_____ Fax #:____-____-_____

	Retail	Mail Order	Specialty Drug
Toll-free account management line:	_____	_____	_____
Toll-free retail customer service line:	_____	_____	_____
Call abandonment rate:	_____	_____	_____
Can you monitor abandon rate on a client specific basis?	**YES / NO**	**YES / NO**	**YES/NO**
Average answering speed:	_____	_____	_____
Can you monitor answering speed on a client specific basis?	**YES / NO**	**YES / NO**	**YES/NO**
Do you currently have On-Line Services for members?	**YES / NO**	**YES / NO**	**YES/NO**

If yes what services does you Web Site offer?_____
_____
_____
Web Site Address: _____

13. What are the hours of operation for your organization: (include time zone)

	Retail	Mail Order	Specialty Drug
Claims processing function:	_____	_____	_____
Customer service function:	_____	_____	_____
Pharmacist availability for customer questions:	_____	_____	_____

14. Can you send an explanation of benefits to the member? **YES / NO**
Is there an extra charge for this service? **YES / NO**
If yes, $_____ per explanation of benefits

15. Do you have the capability to coordinate pharmacy benefits (COB) for secondary claimants for:

Retail Claims:	**YES/NO**
Mail Order Claims:	**YES/NO**
Specialty Drug Claims:	**YES/NO**

If so, state demonstrated pharmacy COB savings separately for retail and mail order claims.

_____

_____

16. How do you screen for duplicate prescriptions, therapeutic overlaps and early refills? What savings have you realized?_____

_____

_____

17. Describe the procedures used to establish and maintain your formulary. (Under separate cover include a listing of your organization's current formulary_____

_____

_____

18. The Greater Tompkins County Municipal Health Insurance Consortium Prescription Drug Plan currently offers open formulary plans and a multi-tiered formulary program. The Greater Tompkins County Municipal Health Insurance Consortium is interested in reviewing any non-intrusive formulary programs your organization offers. Please describe them and comment on the savings generated by these programs.

_____

_____

_____

PHARMACY NETWORK:

19. Provide lists of your current network pharmacy locations. This list should be provided on diskette (ASCI or .TXT format) for your all locations. Please include a separate hard copy listing of all the Tompkins, Seneca and Tioga County Pharmacies.

20. How active are your organization's pharmacy recruitment solicitors in the Greater Tompkins Municipal Health Insurance Consortium's area?

_____

_____

If selected, would your organization make a concerted effort to sign on any designated pharmacies in the Greater Tompkins County Municipal Health Insurance Consortium area? **YES / NO**

21. Do your agreements with your network pharmacies include clauses pertaining to the following issues:

Allows on-site audit of all records pertaining to network membership? **YES / NO**

Agrees to comply with the lower of usual and customary or negotiated pricing? **YES / NO**

Agrees to accept DUR and plan parameter messages electronically? **YES / NO**

Maintains records / prescriptions per state regulations? **YES / NO**

Signature logs per state regulations? **YES / NO**

Verifiable records of authorization for refills? **YES / NO**

Suitable hours of operation? **YES / NO**

22. Describe the procedures a network pharmacist would follow to verify eligibility, collect the proper co-pay, and process the claims in routine circumstances:_____

_____

How would these procedures be handled if there was a problem accessing the computer network system?

_____

_____

23. How will information on potential fraud be communicated to The Greater Tompkins County Municipal Health Insurance Consortium?

_____

_____

Is there a minimum dollar threshold regarding fraud investigation? **YES / NO**

Amount? _____

24. Do you electronically audit network pharmacies? **YES / NO**

If yes, please identify those indicators listed below which you monitor for pharmacy auditing purposes.

Indicator	Monitoring Parameter	Frequency of Data Collection
Average Ingredient Cost		
Brand/Generic Dispensing		
Days Supply per NDC		
% of Controlled Substance Dispensed		
Other, Please Specify		

25. What percentage of total network pharmacies was audited on site in 2008? _____

MAIL ORDER PROGRAM:

26. Complete the following information on your proposed mail order pharmacy:
Location of Pharmacy?_____
Date facility became operational?_____
Number of Pharmacists employed?_____
Facility dispensing capacity per week?_____
Average number of prescriptions filled per week in 2006?_____ and 2007 _____

27. Please describe the formulary procedures in the state in which the mail order facility is located? Specifically, what requirements does that state have for; (a) generic substitution, (b) maximum "life" of a prescription, and (c) regulations regarding interstate shipments. Also, describe any other legislative actions which affect drug dispensing in the state where the facility you have selected resides.

_____
_____

28. Do you fill for a 90 day supply if the physician writes it for less than a 90 day supply? **YES / NO**

29. Please provide the frequency distribution for your dispensing times (e.g. % of prescriptions dispensed within one day, two days, three days of receipt). Measure turnaround time from the receipt of the prescription until the drug is actually sent to the member. Include percentage of prescriptions that are held for review with the physician to determine therapeutic efficacy. _____
_____

30. Do you have the on-line capability to track where a mail order prescription is throughout the dispensing process, as well as the shipping date for that prescription? **YES / NO**

SPECIALTY DRUG PROGRAM:

31. Complete the following information on your proposed Specialty Drug Pharmacy:
    Location of Pharmacy?_____
    Date facility became operational?_____
    Number of Pharmacists employed?_____
    Facility dispensing capacity per week?_____
    Average number of prescriptions filled per week in 2006?_____ and 2007 _____

32. Please describe the dispensing and delivery procedures for your Specialty Drug Program.
    _____
    _____

33. Please describe the dispensing support functions of your Specialty Drug Program.
    _____
    _____

34. Please provide the frequency distribution for your dispensing times (e.g. % of prescriptions dispensed within one day, two days, three days of receipt). Measure turnaround time from the receipt of the prescription until the drug is actually sent to the member. Include percentage of prescriptions that are held for review with the physician to determine therapeutic efficacy.
    _____
    _____

35. Do you have the on-line capability to track where a Specialty Drug Prescription is throughout the dispensing process, as well as the shipping date for that prescription?

YES / NO

CLINICAL MANAGEMENT (DUR):

36. Please check the following Drug Utilization Review (DUR) edits which are performed regularly and which are reported by your retail and mail order programs.

RETAIL			
EDIT	**PROSPECTIVE**	**CONCURRENT**	**RETROSPECTIVE**
THERAPEUTIC DUPLICATE			
DRUG/DRUG DUPLICATE			
EARLY REFILLS			
DRUG INTERACTIONS:			
DRUG TO DRUG			
DRUG TO ALLERGY			
DRUG TO AGE			
DRUG TO GENDER			
DRUG TO DISEASE			
OVER UTILIZATION			
FRAUD			
OTHER, PLEASE SPECIFY			
MAIL ORDER			
EDIT	**PROSPECTIVE**	**CONCURRENT**	**RETROSPECTIVE**
THERAPEUTIC DUPLICATE			
DRUG/DRUG DUPLICATE			
EARLY REFILLS			
DRUG INTERACTIONS:			
DRUG TO DRUG			
DRUG TO ALLERGY			
DRUG TO AGE			
DRUG TO GENDER			
DRUG TO DISEASE			
OVER UTILIZATION			

FRAUD			
OTHER, PLEASE SPECIFY			

37. Please check those items listed below which you monitor and profile on a retrospective basis for retail and mail order. The "Time Period Reviewed" refers to the amount of history typically included in each review.

RETAIL		
EDIT	**FREQUENCY OF REVIEW**	**TIME PERIOD REVIEWED**
UNDER UTILIZATION		
OVER UTILIZATION		
BY THERAPEUTIC CLASS / MEDICAL CONDITION		
CONTROLLED SUBSTANCES		
QUESTIONABLE DRUGS (E.G. GROWTH HORMONES, SMOKING CESSATION PRODUCTS)		
PHARMACY DISPENSING		
PHYSICIAN PRESCRIBING		
THERAPEUTIC EFFICACY		

MAIL ORDER		
EDIT	**FREQUENCY OF REVIEW**	**TIME PERIOD REVIEWED**
UNDER UTILIZATION		
OVER UTILIZATION		
BY THERAPEUTIC CLASS / MEDICAL CONDITION		
CONTROLLED SUBSTANCES		
QUESTIONABLE DRUGS (E.G. GROWTH HORMONES, SMOKING CESSATION PRODUCTS)		
PHARMACY DISPENSING		
PHYSICIAN PRESCRIBING		

THERAPEUTIC EFFICACY		

38. Please check those data elements that are captured and reviewed for retrospective DUR.

NDC	
DISPENSING DATE	
QUANTITY	
DAYS SUPPLY	
PHARMACY ID	
PHYSICIAN ID	
INGREDIENT COST	
EMPLOYEE CO-PAYMENT	

39. Describe your methods of contacting physicians with the results of problematic retrospective reviews.
_____
_____

40. Describe any physician profiling efforts conducted by your organization._____
_____
_____

41. Describe any Disease Management Programs conducted by your organization._____
_____
_____

42. Do you have an adverse drug reaction reporting program? **YES / NO**
Are pharmacists alerted to potential adverse drug reactions prior to filling through system edits? **YES / NO**
How often are the edits updated? _____

DRUG REIMBURSEMENT RATES PAID TO PHARMACIES:

1. The Greater Tompkins County Municipal Health Insurance Consortium is requesting information on a variety of pharmacy networks that would be available through your organization. For each of these network programs please indicate your average prescription drug reimbursement rates for both brand name and generic drugs. Your answer should identify the average discount and the data source utilized in determining your reimbursement rate.

Widest Available Retail Network:

Retail Drug:

Network Name:_____ Brand Name: _____ Generic:_____

Dispensing Fee: Brand Name: _____ Generic: _____

Mail Order:

Network Name:_____ Brand Name: _____ Generic:_____

Dispensing Fee: Brand Name: _____ Generic: _____

Specialty Drug:

Network Name:_____ Brand Name: _____ Generic:_____

Dispensing Fee: Brand Name: _____ Generic: _____

Alternate Network:

Retail Drug:

Network Name:_____ Brand Name: _____ Generic:_____

Dispensing Fee: Brand Name: _____ Generic: _____

Mail Order:

Network Name:_____ Brand Name: _____ Generic:_____

Dispensing Fee: Brand Name: _____ Generic: _____

Specialty Drug:

Network Name:_____ Brand Name: _____ Generic:_____

Dispensing Fee: Brand Name: _____ Generic: _____

2. For each of the following prescription drugs please state the cost (the actual negotiated reimbursement rate not taking into account any co-payments) for the prescription drugs listed below. In addition to the mail-order cost sheet, a *separate retail cost list should be produced for each of the following pharmacies located in the Southern Tier and Finger Lakes Region of New York State: Kinney, CVS, RiteAid, Wegmans, and WalMart*, In addition, please identify whether the drug is part of your organization's preferred formulary and if the drug is part of your firm's rebate program. Ensure that your pricing reflects the dosage and the quantity listed for each drug. We have included the NDC number to make it very clear which drugs we are requesting to be priced by each PBM. Please keep in mind that these reimbursement levels may be reviewed on audit within the first year of the program or any time thereafter by the Greater Tompkins County Municipal Health Insurance Consortium. The Greater Tompkins County Municipal Health Insurance Consortium will prosecute to the full extent of the law any company who knowingly provides false or inaccurate information relative to the reimbursement rates requested.

3. Due to the importance of the fee schedule for the services that will be rendered for The Greater Tompkins County Municipal Health Insurance Consortium, any and all fees and/or reimbursements that may be paid by the Health Plan must be identified in this section. This program is to be quoted utilizing a "transparent pricing" model. This means that the chosen provider will not retain any money associated with prescription drug rebates or any money associated with the margin between guaranteed reimbursement rates and the actual amount paid to the pharmacies. All the information contained in this section will be considered as your organization's full proposal and THE GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM WILL NOT MAKE ANY FUTURE PAYMENTS TO YOUR ORGANIZATION IF THEY ARE NOT CLEARLY IDENTIFIED AND QUOTED IN THIS SECTION. For your Proposal to be accepted by The Greater Tompkins County Municipal Health Insurance Consortium, a Corporate Officer of your organization, who has pricing approval authority, must sign off on the fees and/or reimbursements quoted in this section.

Prescription Benefit Manager RFP

Drug Costs

Assume standard # units based on a single Rx (ie. 10 days, 30 days, etc.) and please enter the number of units being priced.

				RETAIL COST						Mail Order Cost	Formulary Drug	Re-bate	Structure of Rebate
Drug Name	Strength	NDC	# of Units Priced	Eckert	CVS	Rite-Aid	Kinney	Wal-mart	Weg-mans				
Actos	45 MG	64764045124									Y/N	Y/N	
Advair Diskus	250-50 MG	00173069600									Y/N	Y/N	
Advair Diskus	500-50 MG	00173069700									Y/N	Y/N	
Alprazolam	.25 MG	59762371904									Y/N	Y/N	
Amlodipine Besylate	5 MG	59762153001									Y/N	Y/N	
Amox TR-K CLV	875-125 MG	00093227534									Y/N	Y/N	
Amoxicillin	500 MG	00781261305									Y/N	Y/N	
Apri	28 Day	00555904358									Y/N	Y/N	
Atenolol	50 MG	63304062210									Y/N	Y/N	
Azithromycin	250 MG	00781149668									Y/N	Y/N	
Carisoprodol	350 MG	00603258232									Y/N	Y/N	
Citalopram Hydrobromide	20 MG	31722020701									Y/N	Y/N	
Clarinex	5 MG	00085126401									Y/N	Y/N	
Cialis	20 MG	00002446430									Y/N	Y/N	
Crestor	20 MG	00310075290									Y/N	Y/N	
Cyclobenzaprine	10 MG	00378075110									Y/N	Y/N	
Cymbalta	60 MG	00002327030									Y/N	Y/N	
Fexofenadine HCL	180 MG	00093725301									Y/N	Y/N	
Fluconazole	150 MG	00172541211									Y/N	Y/N	
Fluoxetine HCL	20 MG	50111064801									Y/N	Y/N	
Fluticasone Propionate Spray	50 MCG	00054327099									Y/N	Y/N	
Gabapentin	300 MG	53746010201									Y/N	Y/N	
Furosemide	40 MG	63304062510									Y/N	Y/N	
Hydrochlorothiazide	25 MG	00172208380									Y/N	Y/N	
Diovan	160 MG	00078035934									Y/N	Y/N	
Hydrocodone Acetaminophen	500;5MG;MG	00406035705									Y/N	Y/N	
Levothyroxine Sodium	100 MCG	00378180901									Y/N	Y/N	
Levothyroxine Sodium	125 MCG	00378181301									Y/N	Y/N	
Januvia	100 MG	00006027731									Y/N	Y/N	
Lexapro	10 MG	00456201001									Y/N	Y/N	
Lisinopril	10 MG	63304053301									Y/N	Y/N	
Lipitor	10 MG	00071015523									Y/N	Y/N	
Lipitor	20 MG	00071015623									Y/N	Y/N	
Lipitor	40 MG	00071015723									Y/N	Y/N	
Lisinopril-HCTZ	20-12.5 MG	00591086101									Y/N	Y/N	
Metformin HCL	500 MG	00093726710									Y/N	Y/N	
Metoprolol Tartrate	50 MG	00378003210									Y/N	Y/N	
Nasonex	50 MCG	00085128801									Y/N	Y/N	
Nexium DR	40 MG	00186504054									Y/N	Y/N	
Norvasc	5 MG	00069153030									Y/N	Y/N	

		RETAIL COST								Mail Order Cost	Formulary Drug	Re-bate	Structure of Rebate
Drug Name	**Strength**		**# of Units Priced**	**Eckert**	**CVS**	**Rite-Aid**	**Kinney**	**Wal-mart**	**Weg-mans**				
Oxycodone-Acetaminophen	5-325	00406051201									Y/N	Y/N	
Omeprazole DR	20 MG	00378615093									Y/N	Y/N	
Plavix	75 MG	63653117101									Y/N	Y/N	
Prednisone	10 MG	00143147310									Y/N	Y/N	
Proair HFA Inhaler	90 MCG	59310057920									Y/N	Y/N	
Pantoprazole Sod DR	40 MG	00008060701									Y/N	Y/N	
Sertraline HCL	100 MG	6818035306									Y/N	Y/N	
Simvastatin	20 MG	00093715456									Y/N	Y/N	
Simvastatin	40 MG	16714068302									Y/N	Y/N	
Singulair	10 MG	00006011754									Y/N	Y/N	
Spiriva Handihaler	18 MCG	00597007541									Y/N	Y/N	
Tricor Tablet	145 MG	00074612390									Y/N	Y/N	
Viagra	100 MG	00069422030									Y/N	Y/N	
Zetia	10 MG	66582041431									Y/N	Y/N	
Zolpidem Tartrate	10 MG	00093007401									Y/N	Y/N	

REFERENCES:

40. Please list five similarly situated clients from whom we can obtain a recommendation.

Client Name: ____
Contact Name: ____
Contact Title: ____
Principal work location: ___________________________________ City: __________________ State: _______
Zip Code:________-_____ County: ________________ Tel.#:____-____-_______ Fax #:____-____-_______
E-Mail Address:___________________________________

Client Name: ____
Contact Name: ____
Contact Title: ____
Principal work location: ___________________________________ City: __________________ State: _______
Zip Code:________-_____ County: ________________ Tel.#:____-____-_______ Fax #:____-____-_______
E-Mail Address:___________________________________

Client Name: ____
Contact Name: ____
Contact Title: ____
Principal work location: ___________________________________ City: __________________ State: _______
Zip Code:________-_____ County: ________________ Tel.#:____-____-_______ Fax #:____-____-_______
E-Mail Address:___________________________________

Client Name: ____
Contact Name: ____
Contact Title: ____
Principal work location: ___________________________________ City: __________________ State: _______
Zip Code:________-_____ County: ________________ Tel.#:____-____-_______ Fax #:____-____-_______
E-Mail Address:___________________________________

Client Name: ____
Contact Name: ____
Contact Title: ____
Principal work location: ___________________________________ City: __________________ State: _______
Zip Code:________-_____ County: ________________ Tel.#:____-____-_______ Fax #:____-____-_______
E-Mail Address:___________________________________

Section IV

COST PROPOSAL

GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

PROPOSAL FORM

PROPOSAL IDENTIFICATION:

Title: Prescription Benefit Manager Services

THE PROPOSAL IS SUBMITTED TO:

Stephen Locey, President, CEO
Locey & Cahill, LLC
120 Walton Street, Suite 500
Syracuse, NY 13202

1. The undersigned Bidder proposes and agrees, if this Proposal is accepted, to enter into a Contract with the owner in the form included in the Contract Documents to complete all Work as specified or indicated in the Contract Documents for the Contract Price and within the Contract Time indicated in this Proposal and in accordance with the Contract Documents.

2. Bidder accepts all of the terms and conditions of the Instructions to Bidders, including without limitation those dealing with the Disposition of Proposal Security. This Proposal may remain open for sixty (60) days after the day of Proposal opening. Bidder will sign the Contract and submit the Contract Security and other documents required by the Contract Documents within fifteen days after the data of Consortium's Notice of Award.

3. In submitting this Proposal, Bidder represents, as more fully set forth in this Contract, that:

   (a) Bidder has examined copies of all the Contract Documents and of the following addenda: (If none, so state)

   Date Number

   (receipt of all of which is hereby acknowledged) and also copies of the Notice to Bidders and the Instructions to Bidders;

   (b) Bidder has examined the site and locality where the Work is to be performed, the legal requirements (federal, state, and local laws, ordinances, rules and regulations) and the conditions affecting cost, progress, or performance of the Work and has made such independent investigation as Bidder deems necessary;

   (c) This Proposal is genuine and not made in the interest of or on behalf of any undisclosed person, firm or corporation and is not submitted in conformity with any agreement or rules of any group, association, organization or corporation; Bidder has not directly or indirectly induced or solicited any other Bidders to submit a false or sham Proposal; BIDDER has not solicited or induced any person, firm or a corporation to refrain from Proposing; and Bidder has not sought by collusion to obtain for himself any advantage over any other Bidder or over the owner.

4. Bidder will complete the Work for the following price(s): (Attach Proposal)

5. Bidder agrees to commence the Work within the number of calendar days or by a specific date indicated in the Contract. Bidder agrees that the Work will be completed within the number of calendar days or by the specific date indicated in the contract.

6. The following documents are attached to, and made a condition of this Proposal:

   (a) Non-Collusion Form
   (b) Insurance Certificate
   (c) Anti-Discrimination Clause
   (d) References as indicated in the specification
   (e) Proposal Sign-Off Sheet
   (f) Any other information required in the specifications

7. Communication concerning this Proposal shall be addressed to:

Stephen Locey, President, CEO
Locey & Cahill, LLC
120 Walton Street, Suite 500
Syracuse, NY 13202
Tel:(315) 425-1424
Fax:(315) 425-1394
Email: slocey@loceycahill.com

8. Terms used in this Proposal have the meanings assigned them in the Contract and General Provisions.

COST PROPOSAL:

Provide proposed pricing for all applicable Administrative, Consulting/Actuarial, Utilization Management, Network Access, or any other services related to the provision of the prescription drug program. As noted above, the Greater Tompkins County Municipal Health Insurance Consortium will not make any future payments to your organization if they are not clearly identified in this section. Should your organization not offer a specific service, you must put a N/A symbol in the response line. Should your organization not delineate services out to the level noted below, you must describe in specific detail what services your fees include.

Also, please indicate if the fees below are per employee per month, per prescription filled, or a flat fee.

a. Prescription Drug Administration Services
   1. Standard "Point of Sale" Provider Submitted Claim _____
   2. Paper Claim Direct Submission _____
b. Prior Authorization / Medical Exception Claims _____
c. Drug Utilization Review (DUR) Services _____
d. Paper Submissions (i.e. Eligibility, COB) _____
e. Rebate Program (describe distribution of rebate, if applicable) _____
f. Full Installation Charges _____
g. Miscellaneous Charges:

Underwriting Charges	_____	Employee ID Cards	_____
Formulary Booklets	_____	Run-out Processing	_____
Customized Report Generation Fees	_____	Enrollment Packages	_____
Claims Forms	_____	Banking Fees	_____
Other Fees:_____		Other Fees:_____	

Proposed by:_____ Date:_____

Organization:_____ Title:_____

_____

SIGNATURE

Section V

MANDATORY DOCUMENTATION

GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM
GENERAL CONDITIONS
NON-COLLUSION CERTIFICATE

NON-COLLUSIVE CERTIFICATION:

(a) By submission of this bid/proposal, each bidder/proposer and each person signing on behalf of any bidder/proposer certifies, and in the case of a joint bid/proposal each party thereto certifies as to its own organization, under penalty of perjury, that to the best of his/her/their knowledge and belief:

1. The prices in this bid/proposal have been arrived at independently without collusion, consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder/proposer or with any competitor;

2. Unless otherwise required by law, the prices that have been quoted in this package have not been knowingly disclosed by the bidder/proposer prior to opening, directly or indirectly, to any other bidder/proposer or to any competitor; and

3. No attempt has been made or will be made by the bidder/proposer to induce any other person, partnership, or corporation to submit or not to submit a bid/proposal for the purpose of restricting competition.

_____
Name of Bidder/Proposer

_____
Signature and Title of Signer

_____
Date

NOTE:

A bid/proposal shall not be considered for award nor shall any award be made where (a) 1, 2 and 3 above have not been complied with; provided, however, that if in any case the bidder/proposer cannot make the foregoing certification, the bidder/proposer shall so state and shall furnish with the bid/proposal a signed statement that sets forth in detail the reason(s) therefore. Where (a) 1, 2, and 3 above have not been complied with, the bid/proposal shall not be considered for award nor shall any award be made unless the head of the purchasing unit of the political subdivision, public department, agency or official thereof to which the bid/proposal is made, or his designee, determines that such disclosure was not made for the purpose of restricting competition.

The fact that a bidder/proposer (a) has published price lists, rates or tariffs covering items being procured, (b) has informed prospective customers of proposed or pending publication of new or revised price lists for such items, or (c) has sold the same items to other customers at the same prices being bid/proposed, does not constitute, without more, a disclosure within the meaning of subparagraph (a) 1.

GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

INSURANCE BINDER

The undersigned agrees to Tompkins County's hold harmless/indemnification language. The undersigned also affirms that the insurance requirements have been discussed with the undersigned's insurance agent, that the cost of required insurance has been considered in the submitted bid price, and that a completed insurance certificate (or certification letter of coverage) has been submitted with the package. Project-specific insurance is acceptable. A certification letter of coverage is a letter from the undersigned's insurance agent stating that if awarded the contract, undersigned will be covered with sufficient insurance to meet the contract requirements.

_____

Authorized Signature

GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM
PURCHASING
2nd FLOOR 125 E COURT ST., ITHACA, NY 14850

DECLINATION OF RESPONSE

If you are not responding to this solicitation, please indicate your reasons by checking any appropriate items below and returning this form to the above address. Your cooperation will be greatly appreciated.

We are not responding for this reason:

- ❑ Items or materials not manufactured by us or not available to our company.
- ❑ Our items or materials do not meet these specifications.
- ❑ Specifications not clearly understood or applicable (too vague, too rigid, etc.)
- ❑ Quantities too small.
- ❑ Insufficient time allowed for preparation of submittal.
- ❑ Incorrect address used. Our correct mailing address is:

  _____

  _____

  _____

- ❑ Other reason: _____

  _____

Please respond:

- ❑ We are unable to respond at this time but would like to continue to receive specifications.
- ❑ We are unable to respond and do not wish to receive notification of specification availability.

Bid/RFP Title:

Firm Name: _____

Address: _____

Signature: _____

PROPOSAL SIGN-OFF SHEET

PROPOSAL TITLE: **GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM**
Request for Proposal (RFP) for Prescription Benefit Manager

Please check off and sign for items below and submit this required sheet with your bid packet; the bid may be rejected if the required documents are not included with the bid.

	DONE	INITIALS
1. Proposal completed		
2. Non-Collusive certificate completed		
3. Anti-Discrimination clause completed		
4. Proof of insurance coverage in amounts required by specification signed by insurance agent enclosed		
5. Addenda (if issued) received		
List Addendum # and dates		
6. Insurance Binder completed		

Please note that by signing below the contractor is certifying that all information provided herein is true and correct to the best of their knowledge.

_____
Name/Title of Authorized Person Submitting Bid

_____
Firm or Corporation Making Bid

_____
Address

_____ _____
Date Federal ID #

_____ _____
Telephone Fax

_____
Signature of Authorized Person Submitting Bid

ANTI-DISCRIMINATION CLAUSE

During the performance of this contract, (the contractor) hereby agrees as follows:

(a) The contractor will not discriminate against any employee or applicant for employment because of age, ancestry, color, disability, gender identity, marital status, national origin, parental status, race, religion, sex, sexual orientation, source of income or veteran status. Such action shall be taken with reference, but not be limited, to: recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff or termination, rates of pay or other forms of compensation, and selection for training or retraining, including apprenticeship and on-the-job training.

(b) The contractor will send to each labor union or representative of workers with which he has or is bound by a collective bargaining or other agreement or understanding, a notice, to be provided by the State Commissioner for Human Rights, advising such labor union or representative of the contractor's agreement under clauses (a) through (f) hereinafter called "non-discrimination clauses". If the contractor was directed to do so by the contracting agency as part of the bid or negotiation of this contract, the contractor shall request such labor union or representative to furnish him with as written statement that such labor union or representative either will affirmatively cooperate, within the limits of its legal and contractual authority, in the implementation of the policy and provisions of these non-discrimination clauses or that it consents and agrees that recruitment, employment and the terms and conditions of employment under this contract shall be in accordance with the purposes and provisions of these non-discrimination clauses. If such labor union or representative fails or refuses to comply with such a request that it furnish such a statement, the contractor shall promptly notify the State Commission for Human Rights of such failure or refusal.

(c) The contractor will post and keep posted in conspicuous places, available to employees and applicants for employment, notices to be provided by the State Commission for Human Rights setting forth the substance of the provisions of clauses (a) and (b) and such provisions of the State's and local Tompkins County Laws against discrimination as the State Commission for Human Rights shall determine.

(d) The contractor will state, in all solicitations or advertisements for employees placed by or on behalf of the contractor, that all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color or national origin.

(e) The contractor will comply with the provisions of Sections 291-299 of the Executive Law and the Civil Rights Law, will furnish all information and reports deemed necessary by the State Commission for Human Rights under these non-discrimination clauses and such sections of the Executive Law, and will permit access to his books, records and accounts by the State Commission for Human Rights, the Attorney General and the Industrial Commissioner for purposes of investigation to ascertain compliance with these non-discrimination clauses and such sections of the Executive Law and Civil Rights Law.

(f) This contract may be forthwith cancelled, terminated or suspended, in whole or in part, by the contracting agency upon the basis of a finding made by the State Commission for Human Rights that the Contractor may be declared ineligible for future contracts made by or on behalf of the State or a public authority or agency of the State, until he satisfies the State Commission for Human Rights that he has established and is carrying out a program in conformity with the provisions of these non-discrimination clauses. Such finding shall be made by the State Commission for Human Rights after conciliation efforts by the Commission have failed to achieve compliance with these non-discrimination clauses and after a verified complaint has been filed with the Commission, notice thereof has been given to the Contractor and opportunity has been afforded him to be heard publicly before three members of the Commission. Such sanctions may be imposed and remedies invoked independently of or in addition to sanctions and remedies otherwise provided by law. The Contractor will include the provisions of clauses (a) through (f) in every subcontract or purchase order in such a manner that such provisions be performed within the State of New York. The Contractor will take such action in enforcing such provisions of such subcontract or purchase order as the contracting agency may direct, including sanctions or remedies for non-compliance. If the Contractor becomes involved in or is threatened with litigation with a subcontractor or vendor as a result of such direction by the contracting agency, the Contractor shall promptly so notify the Attorney General, requesting him to intervene and protect the interests of the State of New York.

GENERAL CONDITIONS ACCEPTED BY:

Firm: _____

By: _____

Date: _____

Title: _____

Form date: August 2011