



Roma Independent School District
608 N. Garcia St.
Roma, TX 78584
Tel. 956-849-1377
Fax 956-849-3118

REQUEST FOR PROPOSALS

Roma Independent School District invites you to submit a Proposal for:

Group Health Insurance

RISD #21-21

RESPONSE MUST BE DELIVERED BY	July 14, 2021 at 10:00 a.m. CST (Note: Without exception – Proposal must be time and date stamped by the Purchasing Department
RESPONSE MUST BE DELIVERED TO	Roma Independent School District Attn: Pedro O. Alaniz, Finance Director 608 N. Garcia St. Roma, TX 78584
ESTIMATED CONTRACT PERIOD	October 1, 2021 to September 30, 2022 with the possibility of extending contract for a second and third year.

Proposals will be submitted online in the Roma ISD eBid System or may also be submitted as hand-delivered sealed proposals at 608 N. Garcia St., Roma, TX 78584. Vendors must login to register, view specifications and submit their response at the following link: <https://risd.ionwave.net>

If hand-delivered please mark the envelope on the outside RISD #21-21 Group Health Insurance.

Roma ISD reserves the right to reject any and all proposals and to accept the proposal the District considers most advantageous.

Group Health Insurance

RISD #21-21

NOTICE TO RESPONDENTS

The Roma Independent School District, also referred to as the “Planholder”, is calling for proposals on Employee Benefit Plans for eligible individuals and their dependents.

Sealed proposals addressed to Pedro O. Alaniz, Finance Director, Roma Independent School, will be received on July 14, 2021 until 10:00 a.m. at which time they will be taken to the Administration Building staff development room, publicly opened, and the names of company(ies) responding shall be announced. Proposals must be in the Roma Independent School District’s possession on or before the aforementioned date and time (no late proposals will be accepted).

EMPLOYEE BENEFIT PLANS

A. Health Plan

Proposals will be submitted online in the Roma ISD eBid System or may also be submitted as hand-delivered sealed proposals at 608 N. Garcia St., Roma, TX 78584. Vendors must login to register, view specifications and submit their response at the following link: <https://risd.ionwave.net>

If hand-delivered please mark the envelope on the outside RISD #21-21 Group Health Insurance.

Roma ISD reserves the right to reject any and all proposals and to accept the proposal the District considers most advantageous.

Questions regarding the RFP of a contractual nature may be e-mailed to Pedro O. Alaniz, Finance Director at palaniz@romaisd.com by June 24, 2021.

Hand-deliver Proposals:

Mail Proposals:

Roma I.S.D.
Attn: Pedro O. Alaniz, Finance Director
608 North Garcia
Roma TX 78584

RISD #21-21 Group Health Insurance

PURPOSE:

The Roma Independent School District - RISD (herein after referred to as District) is soliciting Requests for Proposals (hereafter referred to as an “RFP”) for Group Health Insurance.

BACKGROUND INFORMATION:

The District provides a full range of educational services appropriate to grade levels Pre-K through 12. These include regular and enriched academic education, special education for students with disabilities, gifted and talented classes and many individualized programs, such as specialized instruction for at-risk students and those with limited English proficiency. These basic programs are supplemented by a wide variety of offerings in career and technology, fine arts, and athletics.

The District encompasses approximately 490 square miles in western Starr County along the U.S. Mexico border. The District has projected enrollment of 6,060 students for the 2020-2021 school year. All campuses are fully accredited by the TEA. The District tailors its instructional programs to enrich and expand student learning and exposure to the tenets of responsible citizenship. District leaders believe this philosophy is instrumental in keeping the completion rate high and the District’s number of college-bound students high. The Board constitutes the governing body elected from seven single-member districts and sets the tone for instruction and service to students and patrons with its mission statement and goals.

GOALS & OBJECTIVES

The Roma Independent School District attempts to provide high quality healthcare and related benefits that meet employee needs at a competitive price. The Roma Independent School District has a responsibility to manage insurance costs effectively and efficiently. It also has a responsibility to ensure that the employees have access to quality coverage. The primary goal of this RFP process is to enter into agreement with a provider to provide employees’ benefits at an economical value. All coverage will be effective October 1, 2021. Open enrollment is scheduled for late August and early September 2021.

CURRENT COVERAGE AND SERVICES

A summary of benefits has been provided within this RFP. Additional information has been included with the summary of benefits for each product.

INSTRUCTIONS TO RESPONDENTS

DEVIATION FROM SPECIFICATION

Please read your solicitation documents thoroughly and be sure that the INSURANCE PLAN(S) offered comply(ies) with all requirements. Any variation from the specifications must be clearly indicated on a “Point-by-Point” basis and covered by letter attached to and made a part of your proposal. If no exceptions are noted, and you are the successful vendor, it will be required that the INSURANCE PLANS be provided as specified.

PURPOSE

The purpose of these specifications and request for proposal documents is to describe and ultimately make it possible for the Roma Independent School District to procure the services of selected respondent in response to our Employee Benefit Plans Request for Proposals. The INSURANCE PLAN to be selected and purchased by the Roma Independent School District, is the best value for the district, in accordance with Texas Education Code, section 44.031 purchasing contracts for the purchase of insurance. The Roma Independent School District’s decision shall be final.

INTENT

The INSURANCE PLAN to be furnished under this proposal shall be as specified and shall meet all proposal requirements. There is no intention to disqualify any respondent whose INSURANCE PLANS can meet the requirements as outlined.

SUBMISSION/SCOPE SPECIFICATIONS:

Due Date: July 14, 2021 at 10:00 a.m. (CST)

Request for Proposal RISD #21-21

Project Name: Group Health Insurance

The Board of Trustees for the Roma Independent School District will accept sealed proposals on Request for Proposal No. RISD #21-21 Group Health Insurance as per attached specifications. Please address proposal to:

Roma Independent School District
Att: Pedro O. Alaniz, Finance Director
608 N. Garcia St.
Roma, Texas 78584

Roma Independent School District is soliciting Request for Proposals for Group Health Insurance, RISD #21-21 from May 28, 2021 until July 14, 2021 at 10:00 a.m. Proposals will be submitted online in the Roma ISD eBid System or may also be submitted as hand-delivered sealed proposals at 608 N. Garcia St. Roma, Texas 78584. Vendors must login to register, view specifications, and submit their response at the following link: <https://risd.ionwave.net>

If hand-delivered please mark the envelope RISD#21-21 Group Health Insurance.

Roma Independent School District reserves the right to reject any and all proposals and to accept the proposal the District considers most advantageous.

PREPARATION OF PROPOSAL

Proposals MUST give full firm name and address of respondent, and be manually signed. Failure to do so will disqualify your proposal. Person signing proposal must show title or AUTHORITY TO BIND HIS/HER FIRM IN A CONTRACT. Firm name and authorized signature must appear on each page that calls for this information. The legal status of the Respondent whether corporation, partnership, or individual, shall also be stated in the proposal. A corporation shall execute the proposal by its duly authorized officers in accordance with its corporate by-laws and shall also list the state in which it is incorporated. A partnership Respondent shall give full names and addresses of all partners. All partners

shall execute the proposal. Partnership and Individual Respondent shall state in the proposal the names and addresses of all persons with a vested interest therein. The place of residence of each Respondent, or the office address in the case of a firm or company, with county and state and telephone number, shall be given after the signature.

ALTERATIONS/AMENDMENTS TO PROPOSAL

Proposals CANNOT be altered or amended after opening time. Alterations made before opening time must be initialed by respondent guaranteeing authenticity. No proposal may be withdrawn after opening time without acceptable reason in writing and only after approval by the Roma Independent School District.

NO RESPONSE

If unable to respond, respondent should return inquiry-giving reasons.

EXCEPTIONS

The respondent shall attach to his/her proposal, any exceptions to the specification requirements.

DISCREPANCIES

In the event of discrepancies in extension(s), unit price(s) will govern. Proposals subject to unlimited price increase will not be considered.

ACTION TAKEN

Roma Independent School District may hold proposals 120 days after reading of same without taking action. Respondents shall hold their proposals firm for the same period of time.

SYNONYM

Where in this proposal package INSURANCE PLANS is used, its meaning shall refer to the Employee Benefit Plans as described in the Instructions to Respondents.

RIGHT TO WAIVE/TAKE EXCEPTION

The Roma Independent School District reserves the right to waive or take exception to any part of these specification requirements when in the best interest of the Roma Independent School District.

SHORT-LISTED FIRMS

Several firms may be short-listed for further consideration, and may be required to submit supplemental information and/or asked to participate in informal meetings/presentations. The Roma Independent School District reserves the right to obtain clarification of any information in the proposal response. Failure of respondent to timely and sufficiently answer such request(s) for additional information and/or clarification may result in rejection of the proposal from further consideration.

PUBLIC PRESENTATIONS

Additionally, after the review, the Roma Independent School District may require that formal public presentation be made before the selection committee and/or school board.

EXPENSES

If a firm is asked to make a presentation to the selection committee and/or school board, all expenses associated with travel, lodging, meals, etc., shall be borne by the firm. By the same token any expense(s) incurred by the respondents in putting together their proposal shall be the responsibility of the respondent. The Roma Independent School District shall not be responsible for any reimbursements to any firm.

INFORMATION

Roma Independent School District reserves the right to accept or reject all or any part of the proposals, waive minor technicalities, and award the proposal to best serve the interest of the Roma Independent School District. The Roma Independent School District also reserves the right to waive or dispense with any of the formalities contained herein.

Proposals are to be submitted on the basis of the specifications/requirements contained herein. Alternate proposals will also be considered, provided the alternatives are clearly explained. All deviations from the specifications must be clearly identified and explained.

The information contained herein is believed to be accurate and up-to-date, but is not intended to be an express or implied warranty.

Proposals shall be accepted if delivered in person or by the U.S. Postal Service, Federal Express, UPS, etc. Roma Independent School District will not be responsible for missing, lost, or late mail. Proposals may also be submitted online using the following link: <https://risd.ionwave.net>

LEGAL

All parties submitting proposals are expected to comply with federal, state and local laws and regulations relative to the preparation of proposals and the services to be provided. Specifically, the services to be provided are expected to be in compliance with the American with Disabilities Act (ADA), insurance laws and insurance regulations. All proposals that are submitted will be presumed to be in compliance with all applicable laws.

COMMUNICATION

Primary communication shall be via the internet. Request for Proposal packet, and addenda shall be posted on the internet. This project is being administered by the Roma Independent School District, Pedro O. Alaniz, Finance Director, e-mail: palaniz@romaisd.com, Phone: (956)849-1377, Fax (956) 849-3118.

INDEMNIFICATION CLAUSE

The Respondent hereby agrees to protect, defend, indemnify and hold the Roma Independent School District and its employees, agents, officers and servants free and harmless from all losses, claims, liens, demands and causes of action of every kind and character including, but not limited to, the amounts of judgments, penalties, interests, court costs, legal fees, and all other expenses incurred by the Roma Independent School District arising in favor of any party, including claims, liens, debts, personal injuries, including employees of the Roma Independent School District, death or damages to property (including

property of the Roma Independent School District) and without limitation by enumeration, all other claims or demands of every character occurring or in any ways incident to, in connection with or arising directly or indirectly out of this contract. Respondent agrees to investigate, handle, respond to, provide defense for and defend any such claims, demand, or suit at the sole expense of the Respondent. In addition, the Respondent shall protect, defend, indemnify and hold the Roma Independent School District and its employees, agents, officers and servants free and harmless from all losses, claims, liens, demands and causes of action relating to, for, or on account of the use of patented appliances, products or processes, and he shall pay all royalties and charges which are legal and equitable. Evidence of such payment or satisfaction shall be submitted upon request of the Finance Director, as a necessary requirement in connection with the final estimate for payment in which such patented appliance, products or processes are used. Respondent also agrees to bear all other costs and expenses related thereto, even if the claim or claims alleged are groundless, false or fraudulent. This provision is not intended to create any cause of action in favor of any third party against Respondent or the Roma Independent School District or to enlarge in any way the Respondent's liability but is intended solely to provide for indemnification of the Roma Independent School District from liability from damages or injuries to third persons or property arising from Respondent's performance hereunder.

ADDENDA

Respondent shall carefully examine the proposal forms, specifications, and Instructions to Respondents. Should the respondent find discrepancies in, or omissions from proposal forms, specifications, or other documents, or should he/she be in doubt as to their meaning, he/she should at once notify the Finance Director (956)849-1377 and obtain clarification by addendum prior to submitting any proposal. Explanations, interpretations, and supplemental instructions shall be in the form of written Addenda which shall become a part of the Contract documents. Said Addenda shall be mailed by certified mail (return receipt requested), e-mailed, hand delivered and/or faxed, to all prospective Respondents. All Addenda issued in respect to this project shall be considered official changes to the original proposal documents. Verbal statements in response to inquiries and/or requests for explanations shall not be authoritative or binding. It shall be the Respondents' responsibility to ensure that they have received all Addenda in respect to this project. Furthermore, Respondents are advised that they must recognize, comply with, and attach a signed copy of each Addendum which shall be made part of their Proposal Submittal. Respondents' signature on Addenda shall be interpreted as the respondent's "recognition and compliance to" official changes as outlined by the Roma Independent School District and as such are made part of the original solicitation documents. Failure of any Respondent to receive any such addendum or interpretation shall not relieve such Respondent from its terms and requirements.

ASSIGNMENT

Neither the Respondent's contract nor payment due to an awarded vendor may be assigned to a third party without the written approval of the Purchasing and Contracting Department for the Roma Independent School District.

INTERPRETATIONS

Any questions concerning the conditions and/or specifications/requirements with regards to this solicitation for Proposals shall be directed to the designated individuals as outlined in the Request for Proposals. Such interpretations, which may affect the eventual outcome of this request for Proposals, shall be furnished in writing to all prospective Respondents via Addendum. No interpretation shall be considered binding unless provided in writing by the Roma Independent School District in accordance with section entitled "ADDENDA."

GEOGRAPHICALLOCATION

The geographical location(s) of respondent will be a factor in the evaluation and award of contract.

STATUTORYREQUIREMENTS

It shall be the responsibility of the successful Respondent to comply with all applicable State & Federal laws, Executive Orders and Municipal Ordinances, and the Rules and Regulations of all authorities having jurisdiction over the work to be performed hereunder and such shall apply to the contract throughout, and that they will be deemed to be included in the contract as though written out in full in the contract documents. (To include issues related to health, environmental, and safety to name a few.)

RESPONDENT’SEMPLOYEES

Neither the Respondent nor his/her employees engaged in fulfilling the terms and conditions of this Service Contract shall be considered employees of the Roma Independent School District. The method and manner of performance of such undertakings shall be under the exclusive control of the vendor on contract. The Roma Independent School District shall have the right of inspection of said undertakings at any time.

CONFIDENTIALINFORMATION

Any information deemed to be confidential by the respondent should be clearly noted on the pages where confidential information is contained; however, the Roma Independent School District cannot guarantee that it will not be compelled to disclose all or part of any public record under the Texas Public Information Act, since information deemed to be confidential by the Respondent may not be considered confidential under Texas Law, or pursuant to a Court order.

VERBAL THREATS

Any threats made to any employee of the Roma Independent School District, be it verbal or written, to discontinue the providing of item/material/services for whatever reason and/or reasons shall be considered a breach of contract and the Roma Independent School District will immediately sever the contract with the Vendor on contract.

AUDIT

The Roma Independent School District reserves the right to audit the vendor’s books and records relating to the performance of this contract. The Roma Independent School District, at its own expense, shall have the right at all reasonable times during normal business hours and upon at least twenty-four (24) hours’ advance notice, to audit, to examine, and to make copies of or extracts from the books of account and records maintained by the vendor(s) with respect to the Supply/Service and/or Purchase Contract. If such audit shall disclose overpayment by Roma Independent School District to vendor, written notice of such overpayment shall be provided to the vendor and the amount of overpayment shall be promptly reimbursed by vendor to the Roma Independent School District. In the event any such overpayment is not paid within ten (10) business days after receipt of such notice, the unpaid amount of such overpayment shall bear interest at the rate of one percent (1%) per month from the date of such notice until paid.

MATHEMATICAL ERRORS

In the event that mathematical errors exist in any proposal, unit prices/rates v totals, unit prices/rates will govern.

PAST PERFORMANCE

Vendors' past performance shall be taken into consideration in the evaluation and award of a Service Contract.

JURISDICTION

Contract(s) executed as part of this solicitation shall be subject to and governed under the laws of the State of Texas. Any and all obligations and payments are due and performable and payable in Starr County, Texas.

VENUE

The parties agree that venue for purposes of any and all lawsuits, cause of action, arbitration, and/or any other dispute(s) shall be in Starr County, Texas.

CONFLICT OF INTEREST

CHAPTER 176 OF THE TEXAS LOCAL GOVERNMENT CODE Effective January 1, 2006, Chapter 176 of the Texas Local Government Code requires that any vendor or person considering doing business with a local government entity disclose in the Questionnaire Form CIQ, the vendor or person's affiliation or business relationship that might cause a conflict of interest with a local government entity. By law, this questionnaire must be filed with the records administrator of the Roma Independent School District not later than the 7th business day after the date the person becomes aware of facts that require the statement be filed. See Section 176.006, Local Government Code. A person commits an offense if the person violates Section 176.006, Local Government Code. An offense under this section is a Class C misdemeanor.

For more information or to obtain Questionnaire CIQ go to the Texas Ethics Commission web page at www.ethics.state.tx.us/forms/CIQ.pdf.

If you have any questions about compliance, please consult your own legal counsel. Compliance is the individual responsibility of each person or agent of a person who is subject to the filing requirement. An offense under Chapter 176 is a Class "C" Misdemeanor.

NON-APPROPRIATION CLAUSE

For purposes of this project, award will be contingent on approval of budget. In the event that no funds are appropriated for this specific purpose, the Roma Independent School District reserves the right to cancel/terminate this contract. The Roma Independent School District shall be relieved of any and all responsibilities and/or obligations, without penalty(ies) of any sort. The Respondent shall be notified in written form of the Roma Independent School District's intent to cancel/terminate said contract due to lack of funds.

OMISSIONS

At the time of the opening of proposals each respondent will be presumed to have read and to be thoroughly familiar with the requirements of the proposal packet. The failure or omission of any respondent to examine any form, instrument or contract document shall in no way relieve any respondent from any obligation in respect to their proposal.

COSTS FOR PREPARATION OF PROPOSAL

The Roma Independent School District shall not be held liable for any costs incurred by any Respondent for work performed in the preparation of and production of a proposal or for any work performed prior to execution of contract.

PAYMENT IF CONTRACT IS TERMINATED

The Roma Independent School District, by written notice, may terminate this contract, in whole or in part, when it is in the District's interest. If this contract is terminated, the Recipient shall be entitled only for payment under the payment provisions of this contract for services rendered before the effective date of termination.

PAYMENT TERMS

By the twentieth (20th) day of each calendar month, Provider shall submit in a form and with detail satisfactory to the Roma Independent School District, a statement of its coverage during the current month from the activity recorded and computed, said statement/invoice shall be available to the Employee Benefits Coordinator for further processing. The Roma Independent School District will execute payment by mail once fees for-services are reconciled no later than 45 to 60 days after billing/invoice is periodically turned in, in strict accordance with the Roma Independent School District's required cycle. No other method of payment will be considered. Such billing and payment shall be based on the unit prices set forth in the Contract Documents.

HUB VENDOR(S) CERTIFICATION

State Certified "HUB Vendor(s)" are asked to provide a copy of their certification, if they have not previously done so (information to be faxed to the Finance Director at (956) 849-3118. Purchasing & Contracting Department at (956) 849-3118.

PROPOSAL FORM

Respondents are advised that it shall be a mandatory requirement of this project that all Respondents submit their proposals utilizing the forms that make up this solicitation package. Proposals submitted utilizing other forms and/or formats will not be considered. Respondents must submit an Electronic Copy of their Proposal (PDF version) to include the Excel Spreadsheets (in Excel form) which have been indicated as "Required RFP Response Questionnaire(s)" via CD or USB drive along with their formal Sealed Proposal submittal. Proposal(s) must be submitted in printed "Sealed Proposal" form as well as in "Electronic" form in order to be considered responsive.

REQUIRED FORMS

All Respondents, including the current carrier(s) and/or administrator(s), shall complete the RFP solicitation forms provided. All RFP forms submitted must be signed by an authorized official of the carrier. FAILURE TO COMPLETE RFP FORMS WILL RESULT IN PROPOSAL BEING DISQUALIFIED.

LITIGATION

Be advised that any Respondent that is involved in any litigation with the Roma Independent School District will not be considered for award of this service contract.

ANTI-LOBBYING PROVISION

During the period between RFP solicitation, submission date, and the contract award, Respondents, including their agents and/or representatives/owners, shall not directly or promote their Proposal to any member of the Roma Independent School District Board or staff except in the course of District sponsored inquires, briefings, interviews, and/or presentations requests. Violation of this provision may result in the rejection of the Respondent's Proposal submittal.

DISCLAIMER

While all precautions have been taken to ensure that files on this page will not interfere with or cause damage to your system or its existing data, Roma Independent School District accepts no responsibility for damages that may be caused by these files and makes no other warranty or representation, neither expressed nor implied, with respect to these files. These files are provided "as is" and you, the user, assume the entire risk when you use them.

WAIVER

Due to the electronic transmissions, the Roma Independent School District does not guarantee nor will it be liable for the accuracy of what is read or what is downloaded.

TERM

Base Proposal Term:

RFP's are anticipated to provide a 12-month rate guarantee, with a contract period of October 1, 2021 through September 31, 2022. The Roma Independent School District reserves the right to extend this contract for two (2) additional years, in one (1) year increments if performance of the successful providers is satisfactory, their plan(s), and premiums remain firm.

CONTRACT EXTENSIONS

At the end of the third plan year, Roma Independent School District reserves the right to extend this contract as it deems to be in the best interest of Roma Independent School District. This extension will be twelve (12) month increments for up to an additional twenty four (24) months (2 year option).

However, the Planholder reserves the right to accept a guarantee of less than or more than 12-months if it is in the Planholder's interests. Providers are asked to provide their most competitive offer, in addition to the Base and/or Alternate proposal as requested above.

AGENT COMMISSIONS

Roma Independent School District requests all proposals on a direct basis from vendors. All proposals are to be submitted **NET OF ANY AGENT/BROKER FEES or COMMISSIONS. AN AGENT OF RECORD LETTER WILL NOT BE ISSUED.**

Proposals must be clearly explained and identified. All costs, including optional programs, must be clearly stated and summarized. Exceptions to or deviations from the specifications must be explicitly identified. Each party submitting a proposal is asked to screen their designated proposals for correctness and compliance with the specifications.

DISQUALIFICATION AND REJECTION OF PROPOSALS

Failure to comply with the requirements and/or the procedures set forth herein, or to satisfy the insurance and servicing criteria may result in disqualification. It is not intended that exceptions to the specifications will, in and of themselves, result in disqualification.

ENROLLMENT

The basis for “take-over” of employee benefits for each of the Providers is to be Roma Independent School District’s enrollment records. Each selected Provider is to be expected to provide a knowledgeable person to explain benefit provisions during enrollment meetings. The selected Providers will also be responsible for providing enrollment materials prior to the employee benefit enrollment meetings.

OVERALL REQUIREMENTS

Respondents must be authorized to do business in the State of Texas. All proposals must be in compliance with the Texas Insurance Code and submitted in compliance with section 44.031 of the Texas Education Code.

The respondents must not exclude from Plan participation any actively at work or on-leave, employee and their respective dependents. The Respondent must accept the Roma Independent School District’s current Benefit Booklet/Document(s).

The Roma Independent School District shall not pay commissions on any line of coverage. If any commission fee or other reimbursement arrangements are paid to any individual and/or organization(s), they must be disclosed in the proposal (indicating who is being paid and how much). Each Respondent must sign the enclosed Non-Collusion Affidavit or their proposal shall not be considered.

Respondents must specify all deviations in the quotation from these specifications, existing coverage or plan of benefits under deviation or limitation on each Proposal Form. It is understood that your proposal is in compliance with the specification for any deviation(s) noted on the Proposal Form.

Respondents must specify any and all deviations in their quotation/proposal which differ from the solicitation requirements/specifications, existing coverages, and/or plan of benefits, such deviation and/or limitation must be indicated on each respective “Required RFP Response Questionnaire”/Proposal Form. It is understood that if your proposal(s) do not indicate any deviations and/or limitations, that it is, in compliance with the specification/requirements, existing coverages, and/or plan of benefits as currently indicated. Respondents shall be responsible to process the post run off claims that are incurred not paid.

All records, files, and miscellaneous data necessary to administer the plan shall be and remain the property of the Roma Independent School District.

This Request for Proposal solicitation does not commit the Roma Independent School District to enter into a contract, nor does it obligate them to pay any costs incurred in preparation, submission or presentation of proposals or in anticipation of a contract.

Please fill out the following forms if applicable.

- CIQ Form,
- Edgar Certification Form,
- Felony Conviction Notice,
- Form 1295,
- House Bill 89 Verification Form,
- Non-Collusion Statement,
- W9 Form

EVALUATION PROCESS

All insurance group plans and/or plan options, if more than one, shall be reviewed, evaluated, and awarded individually, or in any combination thereof.

SELECTION CRITERIA / RIGHT TO REJECT

The Roma Independent School District reserves the right to reject any or all of the proposals, in whole or in part; to waive any informality in any proposal, and to accept the proposal which, in its discretion, is the best and most advantageous to the Roma Independent School District. Proposals will be carefully evaluated for cost effectiveness, for coverage provisions, and for compliance with the coverage and servicing criteria contained in the specifications/requirements. The Roma Independent School District reserves the right to issue subsequent specifications/requirements. The contract will be awarded to the vendor who submits the best and most advantageous proposal based on the relative importance of the selection criteria. All insurance plans will be evaluated and awarded individually or in any combination thereof.

While price is a paramount consideration, the Roma Independent School District will take into consideration all outlined factors in determining which is the best and most advantageous proposal. The Roma Independent School District reserves the right to reject any or all proposals, issue a subsequent Proposal Specification, cancel the entire Proposal Specification, and/or remedy technical errors in the Request for Proposal.

EVALUATION FACTORS

Vendor Qualification (33 points)

- Experience in Industry
- References
- Performance
- Financial Stability
- Administration & Technical Capabilities
- Claims Processing
- Management Reporting
- Services Provided
- Regulatory Knowledge of Federal, State and Local Laws, Regulations, Policies & Procedures

Vendor Expenses (33 points)

- a) Fixed Costs (as applicable)
 - Fully insured Plan
 - Pharmacy Discount
 - Provider Discount
 - Cobra Administration Rates
 - Premium Rates
 - Set Up Fees
- b) Other Costs (as applicable)

Vendor Plan (34 points)

- a) Ability to match existing benefits or improve b) Provider Network c) Utilization Management

RESPONSE INSTRUCTIONS AND REQUIREMENTS

1. Required Response Proposal Format and Organization
 - a. A title page for the proposal must show the Group's name, Project #, name of Respondent's firm, address, contact person, contacts' phone number, contacts' e-mail, contacts' fax number, and date. Title page should also indicate which line of coverage for which the proposal has been submitted.
 - b. A table of contents with section numbers must be provided to clearly identify the specified material by section as specified below. Additional tabs within the sections may be added at Respondents discretion but no further sections should be created.
 - c. The proposal should be organized in the following section numbers:

I. Title Page

II. Required Forms

- i. Required RFP Response Questionnaire (Please find this in RFP Attachments)
- ii. Request for Proposal Certification
- iii. Non-Collusion Affidavit
- iv. Conflict of Interest Questionnaire
- v. References
- vi. HIPPA Acknowledgement – Business Associate Agreement

III. Vendor Qualifications

IV. Vendor Expenses

V. Vendor Plan

VI. Samples

VII. Miscellaneous

To determine what might go into Sections III, IV, and V, please refer to Evaluation Factors outlined in the Evaluation Process/Evaluation Factors on the previous page

- d. The questionnaires and worksheets provided in this RFP are designed to verify the Respondent's ability and willingness to meet various requirements and expectations about the services provided to Roma Independent School District. When responding to questionnaires/worksheets, please be specific yet concise with answers. If a numbered question is adequately addressed in a section of your proposal, please reference that section, but still respond to the questionnaire. The response could be highlighted in the body of the proposal for further clarification. Responses to the questionnaires and the worksheets **MUST BE A PART OF YOUR RESPONSE.**
- e. All requested forms and information should be placed in their appropriate section number. To assist, you will see (Response Section XX) by many items listed throughout the duration of the RFP.

2. Proposal Clearly Marked: RFP – Group Health Insurance (Response Section I)

3. Proposal Term (Response Section IV)

Base Proposal Term: RFP's are anticipated to provide a 12-month rate guarantee, with a contract period of October 1, 2021 through September 31, 2022. The Roma Independent School District reserves the right to extend this contract for two (2) additional years, in one (1) year increments if performance of the successful providers is satisfactory, their plan(s), and premiums remain firm.

However, the Planholder reserves the right to accept a guarantee of less than or more than 12- months if it is in the Planholder's interests, providers are asked to provide their most competitive offer, in addition to the Base and/or Alternate proposal as requested above.

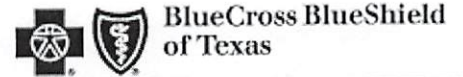
4. Since there are important considerations involved in selecting an administrator in addition to rates, the Planholder will be awarding this RFP based on the best and most advantageous proposal submitted. In addition, the contract will be awarded to the respondent that submits the best and possible RFP based on the relative importance and evaluation factors as outlined (Page 13).
5. The Administrator must submit evidence of ability to service the group without imposing undue time requirements of the Planholders employees. Each Administrator should list three (3) references it services that are approximately our size. References may be checked if deemed advisable. (Response Section II)
6. The Planholder reserves the right to reject any and all Proposals and to accept any Proposals deemed advantageous to the Planholder. Any deviation from these specifications must be stated in detail with complete reference to the RFP specification provision from which the deviation is being made.
7. It is the intention of the Planholder to submit the contract or contracts to be recommended to the governing Board at its meeting in July 2021.
8. All Proposals must be based on exact duplication of the existing plan benefits unless otherwise specified. Any deviation of benefits must be explained in writing and attached to the Proposal for consideration. All Plan Summaries are included as attachments. (Response Section V)
9. HIPAA Compliance with Privacy & Confidentiality guidelines will be required. (Response Section II)
10. All Respondents, including the current carrier or administrator, shall complete the RFP forms provided. All RFP forms submitted must be signed by an authorized official of the carrier. FAILURE TO COMPLETE RFP FORMS WILL RESULT IN PROPOSAL BEING DISQUALIFIED.

11. Respondents Qualifications (Response Section III)
 - a. All companies submitting Proposals must be licensed by the State of Texas and be permitted to contract with the State or any of its subdivisions. Further, it is preferred that companies be recommended in the latest edition of Best's Life Insurance Reports with a general policyholder's rating of A, or in the case of casualty companies have a rating of at least an A in the latest annual edition of Best's Key Rating Guide.
 - b. Respondents who fall under the guidelines of the Texas Political Subdivision Uniform Group Benefits Act (Chapter 172 Local Government Code) and the Inter Local Cooperation Act (Article 4413 (32c) Vernons Texas Civil Statutes will be acceptable.
 - c. All Respondents must provide their firms' most recently audited financial statement.
 - d. Upon termination, claims, prescription claims, accumulators, and eligible individuals will be released at no charge.
12. Plan Administration Qualifications
 - a. Planholder Responsibility: The Planholder will provide for payroll deductions of premium and advise the carrier of additions/deletions from the coverage. The Planholder will assist in the logistics of the enrollment process.
 - b. Selected Administrator Responsibility: The Administrator will provide all necessary materials (e.g. ID cards, Books, etc.) to properly administer the Plan of Benefits. The Administrator will be responsible for the proper adjudication of all claims submitted, stop loss reporting and filing.
13. Provide an organizational chart of all direct functions required to support Roma Independent School District. Names and resumes of key personnel, with an overall proposal contact person should be provided. Telephone numbers, facsimile numbers, e-mail addresses and physical location should also be provided for key contact personnel. Identify who the Account Management team will be. (Response Section III)
14. With the advent of a long term contract, Roma Independent School District's administration is interested in being proactive in managing the cost and benefit makeup of the plans. Although most of the plans are fully insured at this time, it is very important that Roma Independent School District have access to the data required to assist with the management of the plan. Therefore, it is important that Roma Independent School District know exactly what information will be available to them during the year. In light of privacy regulations, please make a statement and provide illustrations as to your company's reporting process. Include in your response any reports available that summarize monthly, quarterly, and semi-annual activity. (Response Section III)
15. Roma Independent School District personnel involved with the evaluation of proposals wish to review anticipated enrollment and initial employee communication materials. Obviously, these instruments have a dramatic effect on an employee's first impression of a new plan. Include a proposed communication package in your response along with any statements regarding recommended distribution techniques for improved understanding of coverages. (Response Section III)
16. Proposal must include the most recent provider listing and/or pharmacy listing for the Starr and Hidalgo County area, including all retail chains and independent providers. The directory should be inserted in your response. (Response Section V)
17. Proposal should include a draft of the Summary of Benefits that would be available for distribution to employees for enrollment purposes and plan inquiry. (Response Section V)

EXHIBIT A:

ROMA ISD INSURANCE PLAN COVERAGES

PPO Insured Standard with Network Deductible



BENEFIT HIGHLIGHTS *Prepared for* Roma ISD – Basic Plan

Effective Date: 10/01/2020

Benefit Agreement #: 0002

Group # 008971

Prepared by: Raquel Wallace Ext. 217-862-6963

BlueChoice Network

****This is a general summary of your benefits.** Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document by calling Customer Service, for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan's limitations and exclusions.

Partial matrix page is attached

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
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Deductibles

Per-admission Deductible

Plan Calendar Year Deductible

Applies to all Eligible Expenses, unless otherwise indicated, except Inpatient Hospital Expenses

Three-month Deductible carryover applies***

Deductible credit from prior carrier (applied on initial group enrollment only)

None
\$500 Individual /
\$1,000 Family

Yes No
 Yes No

\$ 500
\$1,500 Individual /
\$3,000 Family

Yes No
 Yes No

Out-of-Pocket Maximum

Deductibles are not applied to the Out-of-Pocket Maximum. Copayment Amounts are applied but will continue to be required after the benefit percentages increase to 100%. Your benefit booklet will provide more details.

\$3,500 Individual /
\$7,000 Family

Network Deductible & Out-of-Pocket maximum will only apply toward Network Deductible & Out-of-Pocket Maximum

\$10,500 Individual /
\$21,000 Family

Out-of-Network Deductible & Out-of-Pocket will also apply toward Network Deductible & Out-of-Pocket Maximum

Copayment Amounts Required

Physician office visit/consultation

Refer to Medical/Surgical Expenses section for more information

Urgent Care center visit

Refer to Urgent Care section for more information

Outpatient Hospital Emergency Room/Treatment Room visit

Refer to Emergency Room/Treatment Room section for more information

\$35 Copayment Amount

\$35 Copayment Amount

\$50 Copayment Amount

\$50 Copayment Amount

Maximum Lifetime Benefits

Per Participant

Unlimited

Inpatient Hospital Expenses

Inpatient Hospital Expenses

All services must be preauthorized

All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units

Penalty for failure to preauthorize services

For Inpatient Facility Services, Blue Cross Blue Shield of TX or the Host Blue's Participating Provider is required to obtain preauthorization. If preauthorization is not obtained, the Participating Provider will be sanctioned based on Blue Cross Blue Shield of TX or the Host Blue's contractual agreement with the Provider, therefore the member will be held harmless for the Provider sanction

70% of Allowable Amount

None

50% of Allowable Amount after per-admission Deductible

\$250

Medical/Surgical Expenses

Medical / Surgical Expenses

Services performed during the Physician office visit/consultation, including lab & x-ray (does not include Certain Diagnostic Procedures and surgical services)

Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)

-Physician surgical services performed in any setting

100% of Allowable Amount after \$35 Copayment Amount

100% of Allowable Amount

70% of Allowable Amount after Deductible

70% of Allowable Amount after Deductible

70% of Allowable Amount after Deductible

50% of Allowable Amount after Deductible

PPO Insured Standard with Network Deductible



BlueCross BlueShield of Texas

-Physician inpatient hospital visits	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
-Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
-Home Infusion Therapy (Services must be preauthorized)	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
-All other outpatient services and supplies	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
Virtual Visit MDLIVE (standard offering) Note: Must mirror PCP office visit benefit Medical & Behavioral Health Medical Note: Behavioral Health benefit must mirror benefit under Mental Health and Substance Use Disorder Behavioral Health	100% of Allowable Amount after \$35 Copayment Amount	70% of Allowable Amount after Deductible
Note: Behavioral Health Virtual Visit applies to MHP		
In Vitro Fertilization Services	100% of Allowable Amount after \$35 Copayment Amount	70% of Allowable Amount after Deductible

Decline

Extended Care Expenses

In-Network Benefits

Out-of-Network Benefits

Extended Care Expenses

All services must be preauthorized

- Skilled Nursing Facility
- Home Health Care
- Hospice Care

100% of Allowable Amount

70% of Allowable Amount after Deductible

Limited to 25 day maximum each Year*
Limited to 60 visit maximum each Year*
Unlimited

Special Provisions Expenses

Mental Health (Serious Mental Illness (SMI) included) and Chemical Dependency (Substance Use Disorder)

Inpatient Services

Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency/Residential Treatment Center (RTC)

- Hospital services (facility)
- Physician services

70% of Allowable Amount

50% of Allowable Amount after per-admission Deductible
50% of Allowable Amount after Deductible

70% of Allowable Amount after Deductible

None

\$250

Penalty for failure to preauthorize

Preauthorization required for inpatient, residential treatment centers (RTC), partial hospital program admissions, and certain outpatient professional services

Outpatient Services

- Services performed during Physician office visit (does not include psychological testing)
- All outpatient services and psychological testing

100% of Allowable Amount after \$35 Copayment Amount
70% of Allowable Amount after Deductible

70% of Allowable Amount after Deductible
50% of Allowable Amount after Deductible

Emergency Room/Treatment Room

Accidental Injury & Emergency Care

- Facility charges

70% of Allowable Amount after \$50 Copayment Amount
(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)

70% of Allowable Amount after Deductible

- Physician charges

Non-Emergency Care

- Facility charges

70% of Allowable Amount after \$50 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)

50% of Allowable Amount after \$50 Copayment Amount & Deductible
(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)

PPO Insured Standard with Network Deductible



**BlueCross BlueShield
of Texas**

-Physician charges	70% of Allowable Amount after Deductible	will apply) 50% of Allowable Amount after Deductible
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services (<i>does not include Certain Diagnostic Procedures and surgical services</i>)	100% of Allowable Amount after \$35 Copayment Amount	70% of Allowable Amount after Deductible
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan, surgical procedures and all other services and supplies	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
Ground and Air Ambulance Services	70% of Allowable Amount after Deductible	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-Network Benefits
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations for Participants 6 years & over, vision exams, and hearing exams	100% of Allowable Amount after \$35 Copayment Amount	70% of Allowable Amount after Deductible
Immunizations for Dependent children through the date of the child's 6 th birthday	100% of Allowable Amount	
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function	Covered same as any other sickness	Covered same as any other sickness
Hearing Aids	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
Hearing Aid Maximum	Hearing aids are subject to 1 per ear per 36 month period *	
Organ and Tissue Transplant Services	Covered same as any other sickness Refer to benefit booklet for details	Covered same as any other sickness Refer to benefit booklet for details
Physical Medicine Services		
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy)	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
Maximum	Limited to 35 visits each Year*	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

PPO Insured Standard with Network Deductible



BlueCross BlueShield of Texas

Pharmacy Benefits	Participating Pharmacy*	Non-Participating Pharmacy (member files claim)
Drug List** Prescription Drug Deductible***	Preferred Drug List 1	
	<input checked="" type="checkbox"/> None	
Prescription Drug Out-of-Pocket Maximum	<input checked="" type="checkbox"/> None	
Over-the-counter (OTC) medications	<input type="checkbox"/> Covered <input checked="" type="checkbox"/> Not covered, select one: <input checked="" type="checkbox"/> Exclude prescription orders for which there is an OTC product available with the same active ingredient(s) in the same strength (standard exclusion). Cover Omeprazole 20 mg <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exclude brand name drugs in a drug class where there is an OTC alternative available	
Vaccinations obtained through Pharmacies****	Yes, all ACA vaccines, including flu, covered at pharmacies participating in Prime's Vaccination Network only: \$15 Copayment All other in-network pharmacies – appropriate tier copay applies Deductible does not apply	80% of Allowable Amount minus Copayment Amount and deductible
Retail Pharmacy (Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts will not apply to Out-of-Pocket Maximum.) Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name	\$10 Copayment Amount \$20 Copayment Amount \$35 Copayment Amount	80% of Allowable Amount minus Copayment Amount 80% of Allowable Amount minus Copayment Amount 80% of Allowable Amount minus Copayment Amount
Specialty Drugs†	Available at any pharmacy at applicable generic/brand name and participating/non-participating pharmacy benefit level.	
Preferred Pharmacy Retail Network Differential NOTE: Choose a differential only if Preferred Pharmacy Retail Network was selected above.	<input checked="" type="checkbox"/> N/A (Select if not using the Preferred Pharmacy Retail Network) <input type="checkbox"/> Flat <input type="checkbox"/> Add'l \$5 generic/\$10 preferred and non-preferred brand member cost share <input type="checkbox"/> Add'l \$10 generic/\$20 preferred and non-preferred brand member cost share <input type="checkbox"/> Percent- <input type="checkbox"/> Add'l 5% generic/10% preferred and non-preferred brand member cost share <input type="checkbox"/> Add'l 10% generic/10% preferred and non-preferred brand member cost share <input type="checkbox"/> Mixed <input type="checkbox"/> Add'l \$5 generic/10% preferred and non-preferred brand member cost share <input type="checkbox"/> Add'l \$10 generic/10% preferred and non-preferred brand member cost share <input type="checkbox"/> Other (explain)	
Mail Order Program Up to 90 day supply with one copay per 90 days. Copayment amounts will not apply to Out-of-Pocket Maximum. Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No \$20 Copayment Amount \$40 Copayment Amount \$70 Copayment Amount	

PPO Insured Standard with Network Deductible



BlueCross BlueShield of Texas

BENEFIT HIGHLIGHTS *Prepared for* Roma ISD – High Plan

Effective Date: 10/01/2020

Benefit Agreement #: 0001

Group # 008971

Prepared by: Raquel Wallace Ext. 217-862-6963

BlueChoice Network

****This is a general summary of your benefits.** Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document by calling Customer Service, for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan's limitations and exclusions.

Partial matrix page is attached

Overall Payment Provisions

	In-Network Benefits	Out-of-Network Benefits
Deductibles Per-admission Deductible <input type="checkbox"/> Plan <input checked="" type="checkbox"/> Calendar Year Deductible <i>Applies to all Eligible Expenses, unless otherwise indicated, except Inpatient Hospital Expenses</i> Three-month Deductible carryover applies***	None \$250 Individual / \$500 Family <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$ 500 \$500 Individual / \$1,000 Family <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Out-of-Pocket Maximum Deductibles are not applied to the Out-of-Pocket Maximum. Copayment Amounts are applied but will continue to be required after the benefit percentages increase to 100%. Your benefit booklet will provide more details.	\$2,000 Individual / \$4,000 Family <i>Network Deductible & Out-of-Pocket maximum will only apply toward Network Deductible & Out-of-Pocket Maximum</i>	6,000 Individual / \$12,000 Family <i>Out-of-Network Deductible & Out-of-Pocket will also apply toward Network Deductible & Out-of-Pocket Maximum</i>
Copayment Amounts Required Physician office visit/consultation <i>Refer to Medical/Surgical Expenses section for more information</i> Urgent Care center visit <i>Refer to Urgent Care section for more information</i> Outpatient Hospital Emergency Room/Treatment Room visit <i>Refer to Emergency Room/Treatment Room section for more information</i>	\$20 Copayment Amount \$20 Copayment Amount \$50 Copayment Amount	 \$50 Copayment Amount
Maximum Lifetime Benefits Per Participant	Unlimited	

Inpatient Hospital Expenses

Inpatient Hospital Expenses

All services must be preauthorized

All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units

Penalty for failure to preauthorize services

For Inpatient Facility Services, Blue Cross Blue Shield of TX or the Host Blue's Participating Provider is required to obtain preauthorization. If preauthorization is not obtained, the Participating Provider will be sanctioned based on Blue Cross Blue Shield of TX or the Host Blue's contractual agreement with the Provider, therefore the member will be held harmless for the Provider sanction

80% of Allowable Amount

None

60% of Allowable Amount after per-admission Deductible

\$250

Medical/Surgical Expenses

Medical / Surgical Expenses

Services performed during the Physician office visit/consultation, including lab & x-ray (does not include Certain Diagnostic Procedures and surgical services)

Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)

-Physician surgical services performed in any setting

-Physician inpatient hospital visits

100% of Allowable Amount after \$20 Copayment Amount

100% of Allowable Amount

80% of Allowable Amount after Deductible

80% of Allowable Amount after Deductible

70% of Allowable Amount after Deductible

70% of Allowable Amount after Deductible

60% of Allowable Amount after Deductible

60% of Allowable Amount after Deductible

PPO Insured Standard with Network Deductible



BlueCross BlueShield of Texas

-Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan
 -Home Infusion Therapy (*Services must be preauthorized*)

80% of Allowable Amount after Deductible

60% of Allowable Amount after Deductible

-All other outpatient services and supplies

80% of Allowable Amount after Deductible

60% of Allowable Amount after Deductible

80% of Allowable Amount after Deductible

60% of Allowable Amount after Deductible

Virtual Visit MDLIVE (standard offering)
 Note: **Must mirror PCP office visit benefit**
 Medical & Behavioral Health

100% of Allowable Amount after \$20 Copayment Amount

70% of Allowable Amount after Deductible

Medical
 Note: **Behavioral Health benefit must mirror benefit under Mental Health and Substance Use Disorder**
Behavioral Health

100% of Allowable Amount after \$20 Copayment Amount

70% of Allowable Amount after Deductible

Note: Behavioral Health Virtual Visit applies to MHP

In Vitro Fertilization Services

Decline

Extended Care Expenses

In-Network Benefits

Out-of-Network Benefits

Extended Care Expenses

All services must be preauthorized

Skilled Nursing Facility
 Home Health Care
 Hospice Care

100% of Allowable Amount

70% of Allowable Amount after Deductible

Limited to 25 day maximum each Year*
 Limited to 60 visit maximum each Year*
 Unlimited

Special Provisions Expenses

Mental Health (Serious Mental Illness (SMI) included) and Chemical Dependency (Substance Use Disorder)

Inpatient Services

Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency/Residential Treatment Center (RTC)

-Hospital services (facility)
 -Physician services

80% of Allowable Amount

60% of Allowable Amount after per-admission Deductible

80% of Allowable Amount after Deductible

60% of Allowable Amount after Deductible

Penalty for failure to preauthorize
Preauthorization required for inpatient, residential treatment centers (RTC), partial hospital program admissions, and certain outpatient professional services

None

\$250

Outpatient Services

-Services performed during Physician office visit (*does not include psychological testing*)
 -All outpatient services and psychological testing

100% of Allowable Amount after \$20 Copayment Amount

70% of Allowable Amount after Deductible

80% of Allowable Amount after Deductible

60% of Allowable Amount after Deductible

Emergency Room/Treatment Room

Accidental Injury & Emergency Care

-Facility charges

80% of Allowable Amount after \$50 Copayment Amount
 (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)

-Physician charges

80% of Allowable Amount after Deductible

Non-Emergency Care

-Facility charges

80% of Allowable Amount after \$50 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)

80% of Allowable Amount after \$50 Copayment Amount & Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)

PPO Insured Standard with Network Deductible



**BlueCross BlueShield
of Texas**

-Physician charges	80% of Allowable Amount after Deductible	60% of Allowable Amount after Deductible
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services (does not include Certain Diagnostic Procedures and surgical services)	100% of Allowable Amount after \$20 Copayment Amount	70% of Allowable Amount after Deductible
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan, surgical procedures and all other services and supplies	80% of Allowable Amount after Deductible	60% of Allowable Amount after Deductible
Ground and Air Ambulance Services	80% of Allowable Amount after Deductible	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

Special Provisions Expenses, cont.

In-Network Benefits

Out-of-Network Benefits

Preventive Care

Routine annual physical examinations, well-baby care exams, immunizations for Participants 6 years & over, vision exams, and hearing exams
Immunizations for Dependent children through the date of the child's 6th birthday

100% of Allowable Amount after \$20 Copayment Amount

70% of Allowable Amount after Deductible

100% of Allowable Amount

Speech and Hearing Services

Services to restore loss of or correct an impaired speech or hearing function
Hearing Aids

Covered same as any other sickness

Covered same as any other sickness

80% of Allowable Amount after Deductible

60% of Allowable Amount after Deductible

Hearing Aid Maximum

Hearing aids are subject to 1 per ear per 36 month period *

Organ and Tissue Transplant Services

Covered same as any other sickness
Refer to benefit booklet for details

Covered same as any other sickness
Refer to benefit booklet for details

Physical Medicine Services

Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy)

80% of Allowable Amount after Deductible

60% of Allowable Amount after Deductible

Maximum

Limited to 35 visits each Year*

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

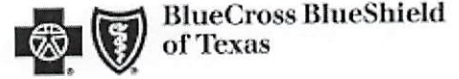
PPO Insured Standard with Network Deductible



BlueCross BlueShield of Texas

Pharmacy Benefits	Participating Pharmacy*	Non-Participating Pharmacy (member files claim)
Drug List** Prescription Drug Deductible***	<input checked="" type="checkbox"/> None	Preferred Drug List 1
Prescription Drug Out-of-Pocket Maximum	<input checked="" type="checkbox"/> None	
Over-the-counter (OTC) medications	<input type="checkbox"/> Covered <input checked="" type="checkbox"/> Not covered, select one: <input checked="" type="checkbox"/> Exclude prescription orders for which there is an OTC product available with the same active ingredient(s) in the same strength (standard exclusion). Cover Omeprazole 20 mg <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exclude brand name drugs in a drug class where there is an OTC alternative available	
Vaccinations obtained through Pharmacies****	Yes, all ACA vaccines, including flu, covered at pharmacies participating in Prime's Vaccination Network only: \$15 Copayment All other in-network pharmacies – appropriate tier copay applies Deductible does not apply	80% of Allowable Amount minus Copayment Amount and deductible
Retail Pharmacy (Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts will not apply to Out-of-Pocket Maximum.) Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name	\$10 Copayment Amount \$20 Copayment Amount \$35 Copayment Amount	80% of Allowable Amount minus Copayment Amount 80% of Allowable Amount minus Copayment Amount 80% of Allowable Amount minus Copayment Amount
Specialty Drugs†	Available at any pharmacy at applicable generic/brand name and participating/non-participating pharmacy benefit level.	
Mail Order Program Up to 90 day supply with one copay per 90 days. Copayment amounts will not apply to Out-of-Pocket Maximum. Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No \$20 Copayment Amount \$40 Copayment Amount \$70 Copayment Amount	

Blue Essentials SM Network
Blue Essentials SM Plan
(HMO)



Insured Benefit Highlights

Prepared For: Roma Independent School District
 Effective Date: 10/01/2020
 Benefit Agreement: 0003
 Prepared by: Raquel Wallace Ext. 217-862-6963

The following chart summarizes the coverage available under the offered HMO plan. All Covered Services (except in emergencies) must be provided by or through the Member's Participating Primary Care Physician/Practitioner (PCP), who may refer them for further treatment by Providers in the applicable network of Participating Specialists and Hospitals. Female Members may visit a Participating OB/GYN Physician in their PCP's Provider network for diagnosis and treatment without a Referral from their PCP. Urgent Care and Retail Health Clinics do not require Primary Care Physician/Practitioner Referral. This summary should be reviewed along with the Limitations and Exclusions.

IMPORTANT NOTE: Copayments and, if applicable, Coinsurance shown below indicate the amount you are required to pay, expressed as either a fixed dollar amount or a percentage of the Allowable Amount. Copayment and any applicable Coinsurance or Deductibles will be applied for each occurrence unless otherwise indicated. Copayments/Coinsurance, Deductibles and out-of-pocket maximums may be adjusted for various reasons as permitted by applicable law. Some services may require Preauthorization by HMO.

Out-of-Pocket Maximums Per Calendar Year

Per Individual Member	\$ 7,500
Per Family	\$ 15,000
Credit for Out-of-Pocket Maximum from prior carrier (Applied on initial group enrollment only)	Yes
OPX, including Deductible, copay and coinsurance will share accums with IPA (Independent Practice Association)	
Deductible applies to Out-of-Pocket	Yes
Copayment applies to Out-of-Pocket	Yes

Deductible Per Calendar Year

Per Individual Member	\$ 1,000
Per Family	\$ 3,000
Deductible credit from prior carrier (Applied on initial group enrollment only)	Yes
Common (One Deductible that applies to Inpatient Facility and Medical/Surgical Services)	
Deductible will share accums with IPA (Independent Practice Association)	

Professional Services

Primary Care Physician/Practitioner ("PCP") Office or Home Visit	\$ 40 Copay
Participating Specialist Physician ("Specialist") Office or Home Visit	\$ 50 Copay

Inpatient Hospital Services

Inpatient Hospital Services, facility per admission	30% Coinsurance after Deductible
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Outpatient Facility Services

Outpatient Surgery	30% Coinsurance after Deductible
Radiation Therapy and Chemotherapy	30% Coinsurance after Deductible
Dialysis	30% Coinsurance after Deductible

Outpatient Laboratory and X-Ray Services

Arteriograms, Computerized Tomography (CT Scan), Magnetic Resonance Imaging (MRI) Electroencephalogram (EEG), Myelogram, Positron Emission Tomography (PET Scan), per procedure	30% Coinsurance after Deductible
Other X-Ray Services	30% Coinsurance after Deductible
Outpatient Lab	30% Coinsurance after Deductible

Diagnostic Mammograms

Diagnostic Mammograms are covered to the same extent as screening mammograms without member age limits as described in the COVERED SERVICES AND BENEFITS; Health Maintenance and Preventive Services.	No Copay
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Rehabilitation Services

Rehabilitation Services and Therapies, per visit

\$ 40 Copay for PCP or \$ 50 Copay for Specialist, 30% Coinsurance after Deductible for Inpatient Hospital Services or 30% Coinsurance after Deductible for Outpatient Facility Services, as applicable.

Maternity Care and Family Planning Services

Maternity Care

Prenatal and Postnatal Visit - Copay is applied to the first office visit only. Subsequent office visits are covered in full.

Inpatient Hospital Services, for each admission

\$ 40 Copay for PCP or \$ 50 Copay for Specialist
30% Coinsurance after Deductible

Family Planning Services:

- Diagnostic counseling, consultations and planning services
- Insertion or removal of intrauterine device (IUD), including cost of device
- Diaphragm or cervical cap fitting, including cost of device
- Insertion or removal of birth control device implanted under the skin, including cost of device
- Injectable contraceptive drugs, including cost of drug
- Vasectomy

\$ 40 Copay for PCP or \$ 50 Copay for Specialist; unless otherwise covered under Contraceptive Services described in **Health Maintenance and Preventive Services**.

\$ 40 Copay for PCP or \$ 50 Copay for Specialist, or 30% Coinsurance after Deductible for Outpatient Surgery, as applicable.

Infertility Services

Diagnostic counseling, consultations, planning and treatment services

Artificial insemination, for each procedure and all services related to procedure (cost of sperm not covered)

\$ 40 Copay for PCP or \$ 50 Copay for Specialist

\$ 40 Copay for PCP or \$ 50 Copay for Specialist, 30% Coinsurance after Deductible for Outpatient Surgery

Pregnancy Terminations, limited to Medically Necessary therapeutic terminations of pregnancy

\$ 40 Copay for PCP or \$ 50 Copay for Specialist, 30% Coinsurance after Deductible for Inpatient Hospital Services, or 30% Coinsurance after Deductible for Outpatient Surgery, as applicable.

Behavioral Health Services

Outpatient Mental Health Care

Same as PCP amount described in **Professional Services**.

Inpatient Mental Health Care

Any charges described in **Inpatient Hospital Services** will apply.

State Mandated Additional Options-

Inpatient Mental Health Care (IM5)

Deductible Applies
Copay-Same as that required for other Inpatient Hospital Services. If the plan has no copayment for Inpatient Hospital Service, there is no copayment

	for inpatient mental health care services under this additional benefit option.
Serious Mental Illness	Benefits paid same as any other physical illness.
Chemical Dependency Services	Benefits paid same as any other Behavioral Health Service.

Emergency Services

Emergency Care	\$ 200 Copay, plus 30% Coinsurance after Deductible, Copayment waived if admitted. (If admitted, any charges described in Inpatient Hospital Services will apply.)
Physician	30% Coinsurance after Deductible

Urgent Care Services

Urgent Care	\$ 40 Copay Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply.
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Retail Health Clinics

Retail Health Clinics	PCP amount listed in Professional Services
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Ambulance Services

Ambulance Services	30% Coinsurance after Deductible
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Extended Care Services

Skilled Nursing Facility Services , for each day, up to 60 days per Calendar Year	30% Coinsurance after Deductible
Hospice Care , for each day	30% Coinsurance after Deductible; unless otherwise covered under Inpatient Hospital Services .
Home Health Care , per visit	30% Coinsurance after Deductible

Health Maintenance and Preventive Services

Well child care through age 17	No Copay
Periodic health assessments for Members age 18 and older	No Copay
Immunizations	
<ul style="list-style-type: none"> • Childhood immunizations required by law for Members through age 6 • Immunizations for Members over age 6 	No Copay
Exam for prostate cancer, once every twelve months	\$ 40 Copay for PCP or \$ 50 Copay for Specialist
Bone mass measurement for osteoporosis	No Copay
Well-woman exam, once every twelve months, includes, but not limited to, exam for cervical cancer (Pap smear)	No Copay
Screening mammogram for female Members age 35 and over and for female Members with other risk factors, once every twelve months	No Copay
<ul style="list-style-type: none"> • Outpatient facility or imaging centers 	No Copay

<p>Contraceptive Services and Supplies</p> <ul style="list-style-type: none"> • Contraceptive education, counseling and certain female FDA approved contraceptive methods, female sterilization procedures and devices • Tubal Ligation <p>Breastfeeding Support, Counseling and Supplies</p> <ul style="list-style-type: none"> • Electric breast pumps limited to one (1) per Calendar Year 	<p>No Copay</p> <p>No Copay</p> <p>No Copay</p>
<p>Hearing Loss</p> <ul style="list-style-type: none"> • Screening test from birth through 30 days • Follow-up care from birth through 24 months 	<p>No Copay</p> <p>No Copay</p>
<p>Rectal screening for the detection of colorectal cancer for Members age 50 and older:</p> <ul style="list-style-type: none"> • Annual fecal occult blood test, once every twelve months • Flexible sigmoidoscopy with hemocult of the stool, limited to 1 every 5 years • Colonoscopy, limited to 1 every 10 years 	<p>No Copay</p> <p>No Copay</p> <p>No Copay</p>
<p>Eye and ear screenings for Members through age 17, once every twelve months</p>	<p>\$ 40 Copay for PCP or \$50 Copay for Specialist</p>
<p>Eye and ear screening for Members age 18 and older, once every two years</p>	<p>\$40 Copay for PCP or \$ 50 Copay for Specialist</p>
<p>Early detection test for cardiovascular disease, limited to 1 every 5 years.</p> <ul style="list-style-type: none"> • Computer tomography (CT) scanning • Ultrasonography 	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>
<p>Early detection test ovarian cancer (CA125 blood test), once every twelve months</p>	<p>\$30 Copay for PCP or \$50 Copay for Specialist</p>

Dental Surgical Procedures

Dental Surgical Procedures (limited Covered Services)	\$40 Copay for PCP or \$50 Copay for Specialist, 30% Coinsurance after Deductible for Inpatient Hospital Services, or 30% Coinsurance after Deductible for Outpatient Surgery, as applicable.
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Cosmetic, Reconstructive or Plastic Surgery

Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services)	\$40 Copay for PCP or \$50 Copay for Specialist, 30% Coinsurance after Deductible for Inpatient Hospital Services, or 30% Coinsurance after Deductible for Outpatient Surgery, as applicable.
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Allergy Care

Testing and Evaluation	30% Coinsurance after Deductible
Injections	30% Coinsurance after Deductible
Serum	30% Coinsurance after Deductible

Diabetes Care

Diabetes Self-Management Training , for each visit	\$	\$40 Copay for PCP or \$50 Copay for Specialist
Diabetes Equipment		30% Coinsurance after Deductible
Diabetes Supplies Some Diabetes Supplies are only available utilizing pharmacy benefits, through a Participating Pharmacy. You must pay the applicable PHARMACY BENEFITS amount shown in the SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS and any applicable pricing differences.	20	30% Coinsurance after Deductible

Prosthetic Appliances and Orthotic Devices

Prosthetic Appliances and Orthotic Devices \$300 maximum benefit for purchase of one (1) wig needed as a result of current chemotherapy or radiation treatment for cancer.	30% Coinsurance after Deductible
Cochlear Implants Limit one (1) per impaired ear, with replacements as Medically Necessary or audiological necessary.	30% Coinsurance after Deductible. Any additional charges as described in Outpatient Surgery may also apply.

Durable Medical Equipment

Choose one and delete the other row
Durable Medical Equipment

30% Coinsurance after Deductible

Durable Medical Equipment (DM8)
Rental or purchase of DME (initial placement only, and standard replacements because of physical growth of members under age 18)

General Payment Level; Deductible Applies

Hearing Aids

Hearing Aids
Maximum benefit - one per ear, every 36 months

30% Coinsurance after Deductible

Pharmacy Benefits

X Prescription Drug Benefits (Prime Therapeutics)

- Prescription Drug Benefits Carved Out
- CVS/Caremark – Provide telephone number or other contact information, if available: _____
- Catamaran – Provide telephone number or other contact information, if available: _____
- Express Scripts/Medco – Provide telephone number or other contact information, if available: _____
- OptumRx – Provide telephone number or other contact information, if available: _____

Drug List**

- Enhanced (open formulary) (Previously drug list 2)
- Performance (closed formulary) (UM package for this drug list will automatically apply)

Note: For non-grandfathered insured business, enhanced is standard. Non-grandfathered insured business may optionally select Performance.

Prescription Drug Out-of-Pocket Maximum

- All benefits, including prescription drug benefits (retail and mail service) apply to the Out-of-Pocket Maximum shown on page 1.
- Separate Prescription Drug Out-of-Pocket Maximum applies to Retail & Mail Service Pharmacy: Individual: \$ / Family: \$

Prescription Drug Deductible***

- None
- All benefits, including prescription drug benefits (retail and mail service) apply to Deductible shown on page 1. Deductible will apply to the Out-of-Pocket Maximum.
- Separate Prescription Drug Deductible applies to Retail & Mail Service Pharmacy: Individual: \$ / Family: \$

Preferred Participating Pharmacy Retail Pharmacy*

One Copayment amount per 30-day supply, up to a 90-day supply only

Extended Supply (if allowed by the Prescription Order) – one Copayment amount per 30-day supply, up to a 90-day supply.

Preferred Generic Drug	\$20 Copay
Non-preferred Generic Drug	\$40 Copay
Preferred Brand Name Drug	\$60 Copay
Non-Preferred Brand Name Drug	\$80 Copay
Out-of-Area Drug	\$N/A Copay

Mail-Order Program*

One Copayment amount per 90-day supply, up to a 90-day supply only

Preferred Generic Drug	\$60 Copay
Non-Preferred Generic Drug	\$120 Copay
Preferred Brand Name Drug	\$180 Copay
Non-Preferred Brand Name Drug	\$240 Copay

Specialty Pharmacy Program

One Copayment amount per 30-day supply, up to a 30-day supply only

Preferred Specialty Drug	\$150 Copay
Non-Preferred Specialty Drug	

**ROMA ISD
BENEFIT SUMMARY**

HMO PLAN

Network:

Blue Essentials

Individual Deductible	\$1,000
Family Deductible	\$3,000
Out of Pocket Individual	\$7,500
Out of Pocket Family	\$15,000
Coinsurance	70%
Primary Care Physician	\$40
Specialist Co Pay	\$50
PREVENTIVE Eye and Ear SCREENINGS	100% \$40/\$50
Inpatient Deductible	Apply (\$1,000)
Inpatient Co Insurance	70%
Emergency Room Co Pay	\$200
Emergency Room Deductible / Co Insurance	Apply (\$1,000) 70%
Outpatient Surgery	Apply (\$1,000)
Out Patient Deductible / Co Insurance	70%
Preferred Generic Drug	\$20
Non Preferred Generic Drug	\$40
Preferred Brand Name Drug	\$60
Non Preferred Brand Name Drug	\$80
Specialty Drugs	\$150

Must Select a Primary Care Physician and List on Application
 Must seek Treatment from Primary Care Phusician for Benefits to Pay
 Get Referral From Primary Care Physician to see an Specialist