SECTION 3

Workbook

(See Attachments)

REQUEST FOR PROPOSAL — SELF-INSURED EMPLOYEE BENEFITS

Texas-Based Self-Insured Employer | Confidential RFP Package

Employer / Plan Sponsor:	San Benito CISD
Plan Effective Date:	1-Oct-26
RFP Issue Date:	1-Apr-26
Proposal Due Date:	28-Apr-26
Plan Situs State:	Texas

RFP SCOPE — VENDOR CATEGORIES

Tab	Vendor Category	Scope
PBM	Pharmacy Benefit Manager	Formulary, rebates, admin fees, clinical programs, MAC pricing, specialty carve-out
ASO/TPA	ASO / Third-Party Administrator	Claims admin, eligibility, reporting, networks, COBRA, FSA/HSA/HRA admin
Network	Provider Network	PPO access fees, discount guarantees, tiered options, wrap networks (TX-specific)
Stop Loss	Stop Loss / Excess Loss	Specific & aggregate coverage, lasers, run-in/run-out, accommodation language
Glossary	Terms & Definitions	Key self-insurance terminology and contractual definitions

GENERAL INSTRUCTIONS TO VENDORS

1. Complete ALL tabs in this workbook. Incomplete proposals will be disqualified.
2. Do NOT alter the structure, formulas, or column headers of any tab.
3. Enter responses in YELLOW-highlighted cells only. Blue cells contain formulas.
4. All pricing must be guaranteed for a minimum of 12 months from the effective date.
5. Provide a full list of contractual exceptions or 'standard' language deviations in writing.
6. Proposals must include performance guarantees with financial teeth (penalty amounts).
7. Rebates must be disclosed at the point-of-sale basis AND per-member basis.
8. All administrative fees must be unbundled and quoted on a PEPM basis.
9. The plan sponsor reserves the right to negotiate contract terms prior to award.
10. Submit completed workbook plus all required attachments by the Proposal Due Date.

PHARMACY BENEFIT MANAGER (PBM) — RFP QUESTIONNAIRE & RATE SHEET

Vendor Name:	Option 1	Option 2	Option 3

SECTION A — ADMINISTRATIVE FEES (Per Employee Per Month)

Fee Component	Option 1	Option 2	Option 3	Notes / Requirements
Retail Rx Claims Processing Fee (PEPM)				*Quote per paid claim and PEPM*
Mail Order Processing Fee (PEPM)				*Include per-fill fee alternative*
Specialty Rx Processing Fee (PEPM)				
Clinical Management / Formulary Mgmt Fee				
Reporting & Analytics Fee				*Must include real-time dashboard*
Eligibility / EDI Fee				
Prior Authorization Administration				
Member Services / Call Center Fee				
TOTAL Admin Fee (PEPM)	**$0.00**	**$0.00**	**$0.00**	*Formula – auto-calculated*

SECTION B — REBATE GUARANTEES (Per Paid Claim)

Rebate Category	Option 1	Option 2	Option 3	Plan Sponsor Requirement
Brand Retail — Preferred Tier				*Pass-through: 100% to Plan*
Brand Retail — Non-Preferred Tier				*Pass-through: 100% to Plan*
Mail Order Brand — Preferred				*Pass-through: 100% to Plan*
Specialty Brand				*Minimum $X guarantee required*
Performance / Supplemental Rebates				*Disclose methodology*
Administrative / Mgmt Rebate Retained				*Must be $0 (full pass-through)*
TOTAL Estimated Annual Rebates				*Provide member-count assumption*

SECTION C — PRICING GUARANTEES & MAC LIST REQUIREMENTS

Pricing Metric	Option 1	Option 2	Option 3	Requirement / Notes
Retail Generic Discount (% off MAC)				*State MAC list brand/version*
Retail Brand Discount (AWP - X%)				*AWP source must be disclosed*
Mail Order Generic Discount (% off MAC)				
Mail Order Brand Discount (AWP - X%)				*Guarantee for 24 months*
Specialty Drug Discount (AWP - X%)				*Carve-out option available?*
MAC List Update Frequency				*Min monthly; weekly preferred*
MAC Appeals Response SLA (days)				*Max 3 business days required*
Effective Generic Dispensing Rate Guarantee				*State GDR % for TX market*
Ingredient Cost Guarantee (% of billed)?				*Y/N + methodology*

SECTION D — PERFORMANCE GUARANTEES (Financial Penalties Required)

Guarantee Metric	Target	Penalty at Risk	Option 1 (Y/N)	Option 2 (Y/N)	Option 3 (Y/N)	Met Y/N Logic
Member ID Card Issuance (days)	≤ 10 days	**2% admin fee at risk**				Missing
Prior Auth Decision Turnaround (hrs)	≤ 24 hrs	**3% admin fee at risk**				Missing
Claims Accuracy Rate	≥ 99.5%	**5% admin fee at risk**				Missing
Formulary Compliance Rate	≥ 92%	**Negotiable**				Missing
Generic Dispensing Rate (GDR)	≥ Guarantee	**3% admin fee at risk**				Missing
Rebate Reporting Timeliness (days)	≤ 90 days	**1% rebate at risk**				Missing
Clinical Program ROI	≥ 3:1	**Negotiable**				Missing
Member Satisfaction Score (CSAT)	≥ 90%	**1% admin fee at risk**				Missing

SECTION E — CLINICAL PROGRAMS & FORMULARY MANAGEMENT

Question	Response
Describe your formulary tiering structure (number of tiers, criteria).	
What is your process and timeline for formulary updates?	
How are step therapy protocols managed and appealed?	
Describe your specialty pharmacy management approach.	
What clinical programs are included at no additional cost?	
How do you manage high-cost/breakthrough therapies (e.g., gene therapy)?	
Describe your opioid management & safety program.	
What formulary exclusions apply? Provide full list.	
Confirm you will allow custom formulary carve-outs (Y/N + conditions).	
Provide your approach to biosimilar substitution policy.	

ASO / THIRD-PARTY ADMINISTRATOR (TPA) — RFP QUESTIONNAIRE & RATE SHEET

Vendor Name:

SECTION A — ASO ADMINISTRATIVE FEES (PEPM Unbundled)

Fee Component	Option 1	Option 2	Option 3	Notes
Medical Claims Administration				*Per paid claim alternative acceptable*
Eligibility Management				*Confirm HIPAA 834 EDI capability*
Benefit Plan Configuration / Setup				*One-time vs. recurring fee*
ID Card Production & Fulfillment				*Digital + physical*
Member Services / Call Center				*Texas call center or toll-free*
Provider Network Access Fee				*Specify network (Blue, PHCS, etc.)*
Reporting & Data Analytics				*Real-time access required*
Subrogation Services				*% of recovery vs. PEPM*
COBRA / State Continuation Administration				
FSA / HRA / HSA Administration				*Itemize per account type*
Dependent Eligibility Audit (DV)				*Annual audit capability required*
HIPAA Compliance & Privacy				
Stop Loss Coordination				*SL carrier agnostic required*
TOTAL ASO Admin Fee (PEPM)	**$0.00**	**$0.00**	**$0.00**	*Auto-calculated*

SECTION B — PERFORMANCE GUARANTEES & SLA REQUIREMENTS

SLA Metric	Plan Requirement	Response 1	Response 2	Response 3
Claims Accuracy (financial)	**≥ 99.0%**			
Claims Turnaround (clean claim)	**≤ 10 business days**			
First Call Resolution Rate	**≥ 85%**			
ID Card Turnaround	**≤ 7 days**			
EOB Accuracy	**≥ 99.0%**			
Auto-Adjudication Rate	**≥ 85%**			
Online Portal Uptime	**≥ 99.5%**			
Reporting Delivery Timeliness	**Monthly ≤ 15th**			
Subrogation Recovery Rate	**State benchmark**			
Implementation Timeline	**≤ 90 days**			
% Admin Fees at Risk for SLA miss	**≥ 5%**			

SECTION C — NETWORK ACCESS & REPRICING REQUIREMENTS (Texas-Specific)

Requirement	V1 Response	V2 Response	V3 Response	Eval Weight
Primary PPO network offered in Texas (name + TPA relationship):				**20%**
Secondary / wrap network availability in rural Texas ZIP codes:				**10%**
Out-of-network repricing methodology and fee schedule:				**10%**
Reference-based pricing option available (Y/N + model):				**10%**
Direct primary care (DPC) integration capability:				**5%**
COE (Center of Excellence) program availability:				**5%**
Network adequacy reporting — how often, format:				**5%**
Provider directory accuracy guarantee SLA:				**5%**
Texas surprise billing / TDI balance billing compliance confirmed:				**15%**

PROVIDER NETWORK — RFP QUESTIONNAIRE & RATE SHEET (Texas Market)

Vendor Name:

SECTION A — NETWORK ACCESS FEES & PRICING

Fee Type	Vendor 1	Vendor 2	Vendor 3	Requirement
Primary PPO Access Fee (PEPM)				*Quote PEPM + per-claim alternative*
Wrap Network Access Fee (PEPM)				*For out-of-area / rural TX coverage*
Network Implementation / Setup Fee				*One-time; waiver requested*
Proprietary vs. Rented Network (specify)				*Disclose if aggregator relationship*
TOTAL Network Access Fees (PEPM)	**$0.00**	**$0.00**	**$0.00**	*Auto-calculated*

SECTION B — DISCOUNT GUARANTEES (Texas Book of Business)

Category	Required Guarantee	V1 Proposed	V2 Proposed	V3 Proposed
Inpatient Hospital — % Savings vs. Billed Charges	**≥ 50%**			
Outpatient Hospital — % Savings vs. Billed Charges	**≥ 45%**			
Professional (Physician) — % Savings vs. Billed	**≥ 30%**			
Emergency Room — % Savings vs. Billed	**≥ 40%**			
Ambulatory Surgery Center — % Savings	**≥ 40%**			
Radiology / Imaging — % Savings	**≥ 45%**			
Lab / Pathology — % Savings	**≥ 50%**			
Mental Health / SUD — % Savings	**≥ 30%**			
Out-of-Network Repricing — % of Medicare	**State methodology**			
Guarantee Basis (Paid Claims vs. Allowed Amount)	**Paid claims basis**			
Discount Guarantee Period (months)	**24 months minimum**			
Auditing Rights — confirm plan sponsor audit rights	**Required**			

SECTION C — TEXAS NETWORK ADEQUACY & COMPLIANCE

Adequacy Item	V1 Response	V2 Response	V3 Response	Requirement
# of contracted PCPs in Texas				**Provide by DMA**
# of contracted specialists in Texas				**Provide by DMA**
# of contracted hospitals in Texas (by tier)				**Include HCA, Baylor, etc.**
Distance-to-provider standards (miles by specialty)				**≤ 15 mi urban / 30 mi rural**
Texas-specific network compliance (TDI Chap 1301)				**Confirm full compliance**
Tiered network option available in TX (Y/N + structure)				**Interested in COE tier**
Direct-to-employer (D2E) contract option available				**Disclose any COE offerings**
Balance billing protection mechanism — TX HB 1733				**Confirm compliance**
Provider directory update frequency				**Monthly minimum required**
Surprise billing protections per No Surprises Act				**Confirm compliance**

STOP LOSS / EXCESS LOSS INSURANCE — RFP QUESTIONNAIRE & RATE SHEET

Carrier Name:

GROUP CENSUS INFORMATION (Complete Prior to Submission)		
Census Item	**Plan Sponsor Input**	**Carrier Confirmation V1**
Total Enrolled Employees	1381	
Covered Lives (EE + Deps)	1771	
Plan Year Start Date	10/1/26	
Specific Deductible Amount ($)	$195,000	
Aggregate Attachment Point Method	125%	*Monthly Aggregate or Annual? Specify*
Run-In Period Claims Data Available?	Paid Contract	*Y/N + months available*
Any Known Laserable Individuals?	No Lasers	*Y/N — if yes, provide de-identified detail*

SECTION A — SPECIFIC STOP LOSS PREMIUM RATES				
Rate Component	**$195,000 Spec.**	**$225,000 Spec.**	**$250,000 Spec.**	**Notes / Requirements**
Specific Deductible:				*Quote at $75K, $100K, $150K options*
Blended Employee PEPM (composite)				*Primary comparison metric*
TOTAL ANNUAL Specific Premium (estimate)	**$0.00**	**$0.00**	**$0.00**	*Based on composite x enrollment*

SECTION B — AGGREGATE STOP LOSS PREMIUM & TERMS				
Aggregate Component	**$195,000 Spec.**	**$225,000 Spec.**	**$250,000 Spec.**	**Notes**
Aggregate Attachment Point (% of Expected)	%	%	%	
Aggregate Premium (PEPM)	$	$	$	
Monthly Attachment Factor (PEPM)	$	$	$	
Aggregate Accommodation Clause (Y/N)				*Required — confirm availability*
Terminal Liability / Run-Out Coverage				*12-month run-out required*
Run-In Credit Available (Y/N + terms)				

SECTION C — CONTRACT TERMS & CLIENT-FAVORABLE PROVISIONS				
Contract Provision	**$195,000 Spec.**	**$225,000 Spec.**	**$250,000 Spec.**	**Required**
Policy type: Incurred & Paid / Paid & Paid / Paid Contract				**If a paid contract is not available, please quote a 24/12.**
Rate guarantee period (months)				**24 months preferred**
Maximum rate increase at renewal (% cap)				**Cap at 15% required**
Laser limitation — confirm no lasers without consent				**No unilateral lasers**
No new laser				**≥ 90 days notice**
Accommodation clause — define threshold				**Required provision**
Claims audit rights (plan sponsor may audit carrier)				**Required**
Dispute resolution process — arbitration vs. litigation				**TX-situs arbitration**
Confirm coverage of transplants, gene therapy, cell therapy				**Required inclusion**
COVID-19 / pandemic exclusion — confirm none				**No pandemic exclusion**
Cancer / chronic condition exclusions — confirm none				**No blanket exclusions**
Mental health / SUD parity compliance confirmed				**Required (MHPAEA)**

SELF-INSURANCE & BENEFITS TERMINOLOGY GLOSSARY

Key terms for self-insured plan administration and vendor contract negotiations

Term	Definition
ASO (Administrative Services Only)	A contractual arrangement where an insurer or TPA administers a self-funded health plan for a flat fee without bearing insurance risk.
Aggregate Stop Loss	Insurance covering total claims exceeding a set threshold (attachment point) for the entire group in a policy year, protecting against catastrophic overall experience.
Aggregate Attachment Point	The dollar level at which aggregate stop loss coverage triggers; typically set at 115–125% of expected claims.
AWP (Average Wholesale Price)	A benchmark price for drugs published by reference sources, used as a basis for PBM discount negotiations.
Balance Billing	When a provider bills a patient beyond the allowed amount; Texas HB 1733 and federal No Surprises Act restrict this practice.
ERISA (Employee Retirement Income Security Act)	Federal law governing most private employer benefit plans; self-funded plans are largely ERISA-preempted from state insurance regulation.
GDR (Generic Dispensing Rate)	The percentage of prescriptions dispensed as generics; a key PBM performance metric that directly impacts plan cost.
HIPAA (Health Insurance Portability and Accountability Act)	Federal law governing health information privacy, security, and electronic transaction standards applicable to self-funded plans.
Laser (Stop Loss)	A specific exclusion or higher deductible applied to an individual member by the stop loss carrier due to known high-cost conditions.
MAC (Maximum Allowable Cost)	The maximum a PBM will reimburse for a generic drug, used to control costs and promote lower-cost generic dispensing.
MHPAEA (Mental Health Parity and Addiction Equity Act)	Federal law requiring mental health/SUD benefits to be no more restrictive than medical/surgical benefits.
PEPM (Per Employee Per Month)	A fee structure expressing vendor costs on a per-enrolled-employee-per-month basis for budgeting and comparison.
PBM (Pharmacy Benefit Manager)	A company that administers prescription drug benefits including formulary management, claims processing, rebate negotiation, and pharmacy network management.
Performance Guarantee	A contractual commitment by a vendor to meet defined service standards, with financial penalties for non-compliance.
Reference-Based Pricing (RBP)	A cost-containment strategy where claims are paid at a set percentage of Medicare rates rather than negotiated network rates.
Run-In Period	Claims incurred before a new stop loss policy's effective date that are covered under the new policy; opposite of run-out.
Run-Out (Terminal Liability)	Coverage for claims incurred during the policy period but not yet paid when coverage ends; critical for plan continuity.
Self-Funded Plan	A health plan where the employer assumes the financial risk for employee health claims rather than paying fixed insurance premiums.
Specific Stop Loss	Per-individual insurance that reimburses the plan for claims exceeding the specific deductible (e.g., $100,000) for any one covered person.
Stop Loss Carrier	The insurance company providing excess-loss coverage to a self-funded employer; rated by AM Best for financial stability.
TDI (Texas Department of Insurance)	The state agency regulating insurance in Texas; TPAs operating in Texas must hold a TDI license.
TPA (Third-Party Administrator)	An entity that processes claims and performs administrative functions for a self-funded plan; must be TDI-licensed in Texas.
Wrap Network	A secondary provider network used to fill geographic gaps in a primary PPO, particularly in rural areas.