REQUEST FOR PROPOSAL

The City of Jackson is seeking bids from responsible firms to provide Third Party Administration for the City of Jackson Medical, Dental and Vision Benefit Plans. Sealed bids will be received by the City Clerk of Jackson, Mississippi at 219 S. President Street Jackson, MS 39201 or at Post Office Box 17, Jackson, Mississippi 39205 **until 3:30 PM, local time (CT), Tuesday September 1, 2026** at which time they will be publicly opened and read aloud for:

To provide Third Party Administration for the City of Jackson Medical, Dental and Vision Benefit Plans. Anticipated date of change is **January 1, 2027**.

Electronic Proposals **MUST** be submitted at www.jacksonmsbids.com. For any questions related to the electronic bidding process, contact PH Bidding at admin@phbidding.com or call 662-407-0193.

Proposals are to be in a sealed envelope plainly marked on the outside. ***"Bid to Provide Third Party Administration of Jackson's Health, Dental and Vision Benefit Plans."***

The City of Jackson is committed to the principle of non-discrimination in public contracting. It is the policy of the City of Jackson to promote full and equal business opportunity for all persons doing business with the City.

Bid preparation will be in accordance with the Instructions to Bidders.

A mandatory pre-bid conference will be held at 1:00 p.m., on **Monday, August 17, 2026** at 633 North State Street, Jackson, Mississippi 39205, 3rd floor. Responders may participate in-person or remotely. All questions regarding the request for proposal, must be submitted in writing by **August 14, 2026** by 12:00 noon. Questions must be emailed to Toya Martin, Director of Human Resources, at tmartin@jacksonms.gov. All questions and responses will be read and answered during the pre-bid conference.

The City reserves the right to reject any and all bids and to waive any and all irregularities in respect to any bid submitted or to accept any bid which is deemed most favorable to the City of Jackson.

Sincerely,

_____

Toya Martin, Director
Department of Human Resources
(601) 960-1327

Dates of Publication:
The Mississippi Link
July 30, 2026
August 6, 2026

REQUEST FOR PROPOSALS

Major Medical, Dental, and Vision Insurance Plans

For City of Jackson, MS Employees, Eligible Retirees, and Eligible Dependents

RFP# 94828-090126

Publication Dates: July30 & August 6, 2026

Responses Due: September 01, 2026

CONFIDENTIALITY STATEMENT

By accessing this RFP, you agree that the information contained herein shall be treated as confidential. The content may only be used for the purpose of responding to the RFP and must not be used for any other purpose beyond the approved scope of work.

Table of Contents

2. Request for Proposals

2.1 Purpose

The City of Jackson, Mississippi (the "City") requests proposals from:

a) third-party administrators (TPAs) and administrative services organizations (ASOs) to provide administration services for its self-funded medical and prescription drug plan through a TPA and/or ASO arrangement;
b) fully insured dental plan; and
c) fully insured vision plan.

Proposers may submit proposals for any single line of coverage or for multiple lines. The City may award one or more lines to one or more vendors, and may reject any or all

proposals, if doing so is in the City's best interest. The selected organization will provide self-funded major medical or fully-insured dental or vision insurance plans, or both or any combination thereof. Services will include related administrative services for eligible City employees, eligible retirees, and eligible dependents.

The City seeks proposals that provide high-value benefits, competitive and sustainable pricing, strong provider access, practical member service, transparent administration, and minimal disruption for employees and retirees.

This procurement represents a key component of the City's ongoing efforts to provide cost-effective, high-quality healthcare benefits while ensuring responsible stewardship of public resources. The City looks forward to receiving proposals from qualified proposers capable of supporting these objectives.

2.2 Procurement Overview

This RFP is issued under applicable Mississippi law, City policy, and the procedures stated in this RFP. Proposals must be complete, responsive, signed, and submitted by the deadline.

The City will evaluate proposals using the published criteria in this RFP. Price/total projected cost is the highest-weighted factor.

No proposal, policy, rate, or administrative-services agreement is binding on the City until approved by the governing authority and executed by authorized representatives.

The City may request best and final offers, interviews, finalist presentations, clarifications, plan design alternatives, or revised pricing.

The City will not reimburse proposal preparation, travel, underwriting, actuarial, or legal costs.

2.3 Current Benefits Background

The City's current medical/Rx and dental plan information, eligibility categories, current rates and contributions, census data, and claims/utilization data will be provided through the RFP data package, a controlled data room, appendices, or written addenda. Because vision coverage has not been previously offered by the City, no historical vision claims or utilization data is available. Proposers must rely only on the RFP, the controlled data package, and written addenda when underwriting or pricing proposals.

Access to Historical Claims and Underwriting Information

Historical claims experience, enrollment data, and other supporting underwriting information will be made available to qualified respondents upon request through a secure electronic file-sharing method. To obtain access to this data package, respondents must satisfy the following requirements:

- **Designated Point of Contact:** All requests for historical data must be submitted in writing solely to the HR Director as the designated RFP contact.
- **Confidentiality Requirements:** Access will be granted only upon receipt of a fully executed Non-Disclosure and Confidentiality Agreement (*See Attachment K – Non-Disclosure and Confidentiality Agreement*).
- **Verification:** Access will be authorized following verification of the respondent's participation in the procurement process and receipt of the required documentation

Eligible active employees*.* Regular full-time employees; regular part-time employees working an average of 30 or more hours per week; and any other eligible groups recognized by City policy or law.

Eligible retirees. Retirees under age 65 and dependents, subject to Medicare-related exclusions and City policy; City of Jackson police officers and firefighters and dependents retired under the 20-year plan who are not eligible for or entitled to Medicare benefits; and any other eligible groups recognized by City policy or law.

Dependents. Spouses, children, and other dependents as defined by the applicable plan documents, City policy, federal law, and Mississippi law.

COBRA / continuation. Qualified beneficiaries and continuation participants to the extent required by applicable public-sector COBRA and other continuation laws.

2.4 Definitions

Term	Meaning
ASO	Administrative services only arrangement for a self-funded health plan.

Term	Meaning
BAA	Business Associate Agreement required when an entity performs functions involving PHI as a business associate under HIPAA.
Carrier	An insurer, PPO, dental carrier, vision carrier, TPA, ASO, or other proposer legally authorized to provide proposed services.
City	The City of Jackson, Mississippi.
COBRA	Continuation coverage requirements applicable to state and local government group health plans, as applicable.
Fully insured	A policy under which the carrier assumes insurance risk in exchange for premium.
Self-funded	A policy under which the employer pays employees' medical claims directly and assumes the financial risk for those costs, subject to any stop-loss coverage the City may elect to purchase.
Major Medical	Group health coverage including medical and related benefits; prescription drug coverage should be included unless the City requests otherwise.
Plan Document Hierarchy	The final executed contract, plan document, summary plan descriptions, insurance policy, and any addenda, in that order of precedence unless otherwise stated in the contract.
Plan Year	January 1, 2027 – December 31, 2027
PBM (Pharmacy Benefit Manager)	The entity responsible for administering prescription drug benefits, formulary management, pharmacy network contracting, and rebate administration.

Term	Meaning
Proposal	The complete response submitted by a proposer, including pricing, forms, certifications, and exceptions.
Proposer	Any qualified vendor, carrier, TPA, or entity submitting a formal proposal in response to this RFP.
PHI (Protected Health Information)	Individually identifiable health information created, received, or maintained by the Plan or its Business Associates, as defined under HIPAA regulations.
RFP	This Request for Proposals, including all attachments, appendices, exhibits, and written addenda issued by the City.
RFP Designated Contact	The sole City contact designated in this RFP for procurement communications.
Stop-loss Insurance	Insurance coverage purchased by the City to protect its self-funded plan against catastrophic individual claims (Specific Stop-Loss) or higher-than-expected overall claims (Aggregate Stop-Loss).
TPA (Third Party Administrator)	The entity contracted to perform administrative services, claims processing, and operational functions for the City's self-funded health plan.

3. Scope of Coverage and Services

The City requests proposals for the following lines of coverage and services.

Major Medical / Prescription Drug Coverage: Proposers should provide clearly labeled alternate self-funded, level-funded, ASO, or stop-loss proposals, with disclosure of all risks, fees, and assumptions.

Dental Coverage: Fully-insured dental proposals are required. Proposers may include passive PPO, PPO, indemnity, or other options, but must clearly identify network, reimbursement method, exclusions, waiting periods, and orthodontia availability and employee-paid scenarios.

Vision Coverage: Fully-insured vision proposals are required. Proposers may offer vision PPO, passive PPO, indemnity, or alternative plan designs.

The City may accept or reject any line separately.

All proposals must explicitly detail the local provider network (including a directory or disruption analysis for the Jackson Metropolitan area), out-of-network reimbursement methods, and all coverage exclusions or limitations.

Each proposer shall respond only to the line(s) of coverage for which it is qualified, and all responses must clearly identify which requirements are being addressed for each line.

Optional Alternatives: Alternative plan designs may be proposed to reduce cost, expand access, or improve overall value for the City. However, any alternative proposal must be submitted as a separate, clearly labeled option, and will only be considered if the proposer also submits a plan that substantially matches the City's current benefits, unless otherwise instructed.

3.1. Medical and Prescription Drug Scope of Services (Medical & Pharmacy Proposers Only)

The medical proposal shall address only the self-funded medical and prescription drug plan, including claims administration, network access, pharmacy benefit administration, utilization management, case management, reporting, compliance support, implementation, and transition services. Requirements in this section do not apply to fully insured dental or vision coverage unless expressly stated. Proposers must provide a detailed response demonstrating their capacity to administer the City’s self-funded health and prescription drug plans. Responses must address each operational area below.

Mandatory Response Requirement:

All Proposers submitting a bid for Medical / Prescription Drug Coverage must complete and submit all required questionnaires and exhibits in **Attachment E (E-1 through E-7)**, Pricing Forms **H-1 and H-4**, Network Disruption Form **Attachment I**, and Implementation Plan **Attachment J**. Failure to submit these mandatory attachments in their entirety may render the proposal non-responsive and subject to immediate rejection

3.1.1 Plan Design Administration and Matching

Core Plan Matching: Proposers must demonstrate the capability to administer a self-funded plan design that substantially matches the City's current medical and prescription drug benefit structures.

Deviation Disclosure: Proposers must explicitly identify and itemize every structural deviation from the City's current plan, including but not limited to: deductibles, coinsurance percentages, copays, out-of-pocket maximums, covered services, exclusions, utilization management protocols, formulary tiers, and specialty pharmacy rules.

Self-Funded Cost-Saving Alternatives: Proposers may provide alternative self-funded plan configurations that offer cost-containment opportunities for the City or enhanced choices for members. For each alternative proposed, the proposer must explain the projected impact on claims expenditures, administrative fees (PEPM), member disruption, network configurations, and utilization behavior.

3.1.2 Provider Network Capabilities (Preferred Provider Network) and Contract Pricing Analysis

Network Infrastructure: Proposers must specify the precise commercial network options being offered, including the designated service area, hospital network access, primary/specialty care density, behavioral health access, and urgent care availability within the City of Jackson and surrounding regions.

Provider Disruption Analysis: Based on the City’s historical provider utilization file (if provided), the Proposer must submit a comprehensive geo-access and provider disruption analysis demonstrating the percentage of current match-rates for the City's active employee and dependent population.

Proposers must complete and submit Attachment H - Contract Pricing and Attachment I – Network Disruption and Provider Access Forms located in the

Appendix of this RFP. The City of Jackson will rely heavily on the negotiated hospital, physician, and prescription drug allowed amounts provided in Appendix H to evaluate the financial feasibility and cost-effectiveness of each proposal. Failure to complete these tables in their entirety may result in the disqualification of the proposal.

3.1.3 Prescription Drug (Pharmacy Benefit) Administration

Formulary and Clinical Management: Describe the proposed formulary management system, tier structures, prior authorization workflows, step therapy protocols, and specialty drug management.

Distribution and Accumulator Programs: Detail the availability of mail-order services, 90-day retail maintenance fill programs, copay accumulator/maximizer programs, and insulin/diabetes supply management.

Rebate Transparency: Proposers must explicitly define how pharmacy rebates, manufacturer credits, or discounts are tracked and passed through dollar-for-dollar to the City's self-funded claims fund.

3.1.4 Care and Utilization Management

Clinical Oversight: Describe the proposer's integrated clinical programs, including standard utilization review, disease management, large-case management, maternity support, chronic condition tracking (e.g., diabetes, hypertension), and behavioral health integration.

High-Cost Claimant Support: Detail specific administrative strategies used to identify, monitor, and mitigate catastrophic or high-cost medical claims to protect the City's self-funded financial exposure. Proposers must complete Attachment E-8 (Questionnaire on High Cost Claimant Support) in its entirety.

3.1.5 Administrative Documents and Compliance Support

Plan Documentation Support: The selected TPA must assist the City in drafting and updating its self-funded Summary Plan Descriptions (SPDs), Summaries of Benefits and Coverage (SBCs), plan booklets, and open enrollment materials.

Regulatory Compliance Framework: Identify the administrative support provided to ensure the City remains compliant with federal and state mandates, including but not

limited to: The No Surprises Act (NSA) protections, Mental Health Parity and Addiction Equity Act (MHPAEA) reporting, HIPAA privacy/security regulations, and Affordable Care Act (ACA) reporting workflows.

3.2. Dental Requirements

The dental proposal shall address only fully insured dental coverage and related enrollment, claims, customer service, provider network, reporting, open enrollment support, and implementation services. Medical claims administration, pharmacy benefit administration, and medical utilization management requirements do not apply to the dental proposal unless expressly stated.

The City of Jackson currently offers a voluntary, fully insured dental plan that is 100% employee-paid via payroll deduction and intends to continue to offer the same. The City provides no direct financial contribution toward the premium, nor does the City assume any liability for benefit costs or claims. The City's role is strictly limited to sponsoring the group plan and processing premium payments via payroll deduction.

Mandatory Response Requirement:

All Proposers submitting a bid for Dental Coverage must complete and submit the **Dental Questionnaire in Attachment F and Provider Disruption Analysis** in **Attachment I.** Failure to complete and submit these mandatory attachments in their entirety will render the proposal non-responsive and subject to immediate rejection.

3.3 Vision Requirements

The vision proposal shall address only fully insured vision coverage and related enrollment, claims, customer service, provider network, reporting, open enrollment support, and implementation services. Medical claims administration, pharmacy benefit administration, and medical utilization management requirements do not apply to the vision proposal unless expressly stated.

The City provides no direct financial contribution toward the premium, nor does the City assume any liability for benefit costs or claims. The City's role is strictly limited to sponsoring the group plan and processing premium payments via payroll deduction.

The Vision Questionnaire is Attachment G of this RFP. Failure to complete and submit this mandatory attachment in its entirety will render the proposal non-responsive and subject to immediate rejection.

3.4 Required Objectives

a) Maintain or improve benefit value while controlling total City and employee cost.

b) Minimize provider disruption, especially for high-utilization employees, retirees, dependents, hospitals, primary care, specialists, behavioral health, dental providers, and pharmacies in the Jackson/Hinds County service area.
c) Provide transparent underwriting assumptions and pricing methodology.
d) Provide responsive account management with named contacts and clear escalation channels.
e) Support open enrollment, onboarding, eligibility file exchange, ID card delivery, and member education.
f) Meet applicable federal and state laws for group health plans, dental and vision coverage, privacy, continuation, disclosure, and transparency.
g) Offer meaningful reporting, renewal strategy, utilization review, and cost-containment support.

3.5 Scope Overview

This RFP seeks proposals from qualified organizations capable of providing comprehensive Third-Party Administration services for the City's self-funded medical plan, fully-insured dental or fully-insured vision plan, for an individual line of coverage or any combination thereof. The selected Proposer will be responsible for delivering a full suite of administrative and support functions, including but not limited to:

a) Claims administration and adjudication
b) Provider network access and management
c) Customer service and member support
d) Eligibility and enrollment management
e) Care management and wellness programs
f) Utilization management
g) Reporting and analytics
h) Compliance and regulatory support
i) Implementation and transition services

The Proposer must demonstrate the capacity to administer the plan with accuracy, timeliness, and operational integrity while supporting the City's goals of cost containment, transparency, and high-quality member service.

3.5.1. Detailed Scope of Work

The Proposer shall provide a complete suite of Third-Party Administration services and insurance management services necessary to support the City of Jackson's self-funded medical plan, as well as its fully insured dental and vision plans. All services must be delivered in accordance with applicable federal, state, and local laws, industry best practices, and the performance standards outlined in this RFP. The Proposer must demonstrate the operational capacity, technical capability, and subject-matter expertise required to administer a complex municipal health and welfare plan serving employees, retirees, and dependents.

The Scope of Work includes, but is not limited to, the following service areas:

3.5.2 Claims Administration

The Proposer shall provide accurate, timely, and compliant claims processing services, including:

a) Adjudication of medical claims in accordance with plan documents
b) Coordination of benefits (COB) and subrogation
c) Application of deductibles, copays, coinsurance, and accumulators
d) Fraud, waste, and abuse detection
e) Claims payment accuracy reporting
f) Timely processing standards that meet or exceed industry norms

3.5.3 Preferred Provider Network Access & Management

The Proposer shall provide access to a robust provider network that ensures high-quality, geographically accessible care for members. Requirements include:

a) Comprehensive local, statewide, and national network coverage
b) Network adequacy and disruption analysis
c) Contracting strategies to address identified gaps
d) Provider directory maintenance and accuracy
e) Network performance reporting

3.5.4 Customer Service & Member Support

The Proposer shall operate a dedicated customer service function that includes:

a) A toll-free member services line

b) Trained representatives familiar with City-specific benefits
c) Multilingual support
d) Call center performance metrics and reporting
e) Member education materials, ID cards, SBCs, and digital tools

3.5.5 Eligibility Enrollment Management

The Proposer shall support all aspects of eligibility administration, including:

a) Secure file exchange with the City
b) Eligibility file setup, mapping, and testing
c) Ongoing enrollment updates and error resolution
d) Retiree eligibility management
e) Reconciliation reporting

3.5.6 Case Management and Wellness

The Proposer shall provide integrated care management and wellness services, including:

a) Utilization management
b) Case management and disease management
c) Preventive care programs
d) Wellness initiatives tailored to municipal employees
e) Behavioral health integration
f) Reporting on engagement, outcomes, and cost savings

3.5.7 Reporting and Analytics

The Proposer shall deliver comprehensive reporting and analytics capabilities, including:

a) Monthly, quarterly, and annual reporting packages
b) Predictive analytics and cost-trend analysis
c) Benchmarking against public-sector norms
d) Real-time dashboards and data transparency
e) Custom reporting upon request

3.5.8 Compliance and Regulatory Support

The Proposer shall ensure full compliance with all applicable federal, state, and local laws regulations, and administrative guidelines. The Proposer's obligations shall include, but are not limited to, compliance with and administrative support for:

a) **Federal Health Care Statutes:** ACA, HIPAA, MHPAEA, CAA, and all applicable provisions of the internal Revenue Code (IRC) governing employer-sponsored health and wealth plans.
b) **State Insurance Laws**: All Mississippi Department of Insurance mandates, regulations, and statutory requirements as they apply specifically to the City's fully insured lines of coverage (dental and vision) and self-funded administrative obligations.
c) **Governmental Plan Standards:** Industry best practices from the ERISA that no provision of this contract shall be construed to waive the City of Jackson's status as an ERISA-exempt governmental plan under 29 USC § 1003 (b)(1)
d) **Public Records Act Compliance:** Timely cooperation, retrieval, and provision of plan documentation, claims data summaries, and administrative records necessary to satisfy the City's obligations under the Mississippi Public Records Act (Miss. Code Ann. § 25-61-1 et. seq.) and independent financial or regulatory audits.
e) **Continuation of Coverage and Billing:** Public sector COBRA administration, continuation of coverage requirements, and retiree billing administration
f) **Data Privacy and Security:** Execution and strict adherence to a Business Associate Agreement (BAA) in compliance with HIPAA/HITECH privacy and security standards.
g) And any and all other applicable federal, state, or local laws or regulatory updates enacted during the term of the agreement that govern the administration of municipal health and welfare benefits.

3.5.9 Implementation & Transition Services

The Proposer shall provide a structured, timely implementation process, including:

a) Project management and kickoff
b) Eligibility and data migration

c) System configuration and testing
d) Member communications and ID card distribution
e) Parallel claims testing
f) Go-live readiness review

3.5.10 Audit Rights, Record Retention & Data Access

The Proposer shall comply with all City audit requirements, including:

a) Full access to records, systems, and personnel
b) Support for scheduled and unannounced audits
c) Record retention for at least seven (7) years
d) Data ownership and return of all City data upon termination

3.5.11 Performance Guarantees

The Proposer shall propose measurable performance guarantees tied to:

a) Claims accuracy
b) Customer service responsiveness
c) Care management engagement
d) Network performance
e) Reporting timeliness
f) Implementation milestones

Penalties or fee-at-risk structures required.

3.5.12 Administrative Services

Proposers must complete and submit the Administrative Questionnaires located in Attachments E2-3 in the **Appendix** of this RFP, certifying which services are included in their proposed base administrative fee. Detailed instructions and required response format are provided with the attachment.

4. Cost Proposal Requirements

Proposers shall submit a complete and transparent Cost Proposal that includes all fees, charges, and financial obligations associated with providing Third-Party Administration or administrative services for the City's self-funded medical plan, self-insured dental and/or self-insured vision plan. All pricing must be presented in a clear, itemized format and must

reflect the total cost of services required under this RFP. The City will not be responsible for any costs not expressly identified in the Proposer's Cost Proposal.

The Cost Proposal must include, at a minimum, the following components:

4.1. Administrative Fees

Proposers shall provide detailed pricing for all administrative services, applicable to their line of coverage, including, as applicable:

a) Per-employee-per-month (PEPM) fees for core TPA services
b) Eligibility management and enrollment processing
c) Customer service operations
d) Claims administration
e) Utilization management
f) Care management and disease management (medical only)
g) Reporting and analytics
h) Compliance support

All proposed fees and charges shall remain firm and fixed for the initial term of the contract. The City will not accept or honor any price fluctuations, surcharges, or automatic annual adjustments unless expressly negotiated and approved by the City's governing authority in writing prior to contract execution.

Proposers must clearly specify whether all proposed fees are guaranteed, fixed, or subject to annual adjustment for the duration of the contract with the City of Jackson, MS.

4.1.1 Price Stability and Rate Adjustments

All proposed administrative fees must remain fixed and guaranteed for the initial term of the contract. The City will not accept automatic annual increases or inflation escalators. After the initial term, any request for a rate adjustment must be submitted in writing to the Human Resources Department at least sixty (60) days prior to the contract renewal date. To be considered, the proposer must provide:

a) A detailed explanation of the external factors driving the request (e.g., changes in federal or state regulatory requirements).
b) Documentation showing the direct impact on the proposer's operational costs.

c) No rate adjustment shall be effective until it is formally approved and executed via a written contract amendment by the City's governing authority.

4.2 Network Access Fees

If applicable, Proposers shall disclose:

a) Network access fees (PEPM or percentage-of-savings)
b) Pass-through vs. bundled pricing
c) Any surcharges for out-of-area or national network access
d) Subcontractor network fees and Transparency. The Proposer shall remain fully responsible for all fees, costs, and expenses associated with its subcontractor network. The Proposer must provide a complete, itemized breakdown of all subcontractor fees included in the proposal, including any administrative markups, network fees, or pass-through charges. The City reserves the right to review and reject any proposed subcontractor fees deemed exorbitant, unreasonable, or inconsistent with competitive market rates.

4.3 Limitations on Subcontractor Markups

All subcontractor services utilized under this agreement must be billed to the City at actual cost, or at the predetermined fixed rate established in the proposal. The primary proposer is strictly prohibited from applying exorbitant administrative fees, network access fees, or secondary markups to subcontractor charges. Any allowable subcontractor administrative fee must be disclosed and capped at a fixed percentage or a fixed flat rate for the duration of the agreement.

All network pricing must be fully transparent and clearly defined.

4.4 Care Management & Utilization Management Fees

Proposers are responsible for:

a) Utilization management
b) Case management
c) Disease management
d) Wellness programs
e) Behavioral health programs

Proposers must indicate whether these services are included in the base administrative fee or priced separately.

4.5 Implementation & Transition Costs

Proposers shall identify all one-time or recurring costs associated with:

a) Implementation and project management
b) Eligibility file setup and testing
c) System configuration
d) Member communications and ID cards
e) Claims run-out support
f) Data migration and integration

No additional implementation fees will be permitted.

4.6 Minimum Mandatory Requirement

Minimum Mandatory Requirement: Proposers must provide a comprehensive, standard telehealth/virtual care program (including 24/7 access to board-certified physicians for primary care, urgent care, and behavioral health consultations). This standard virtual care capability must be included within the base administrative fee or core network access fee at no additional cost to the City or its members.

Evaluation Preference: During the evaluation process, the City will give distinct preference to Proposers who demonstrate that advanced or enhanced virtual care capabilities—such as specialized virtual chronic condition management (e.g., diabetes, hypertension), or digital dermatology—are integrated directly into their core benefit offering without separate, a la carte, or supplemental PEPM charges.

Disclosure of Surcharges: Any Proposer attempting to assess a separate fee, surcharge, or standalone subscription cost for baseline telehealth services must explicitly disclose such charges in the Cost Proposal.

4.5 Optional or Value-Added Services

Proposers shall list and price any optional services.

Enhanced analytics or predictive modeling: Identify all costs for advanced data scrubbing, predictive clinical forecasting, or custom reporting dashboards. Proposers

must explicitly state whether standard quarterly utilization and financial reporting are included in the base administrative fee or if they carry an additional charge.

Wellness incentives & Fund Allowance: Detail the administrative fees for managing, tracking, and validating employee wellness compliance or incentive distribution. Proposers must distinguish between the cost to administer the platform and the actual funding mechanism for the rewards/incentives themselves.

Additionally, state whether the Proposer offers an annual client wellness budget or financial stipend to the City (e.g., dedicated wellness fund/allowance). If applicable, specify:

1. The total annual dollar amount provided to the City;
2. How and when funds are allocated or reimbursed; and
3. Any restrictions, eligible expense categories, or approval requirements for utilizing the funds.

Retiree billing or COBRA administration: Provide itemized pricing for complete compliance management, including sending required notifications, premium billing, collection, and coverage termination workflows. Specify fees on a per-notification or per-active-participant-monthly basis.

Pharmacy carve-out support: Specify all one-time technical implementation fees or ongoing data-syncing fees required to integrate and share real-time eligibility, claims, and deductible accumulators with a third-party Pharmacy Benefit Manager (PBM) selected by the City.

Prohibition on Unsolicited Direct Member Contact and Incentive Programs: Proposers are strictly prohibited from initiating unsolicited direct telephonic, electronic, or mail outreach to covered City employees or dependents for care management, preventive care reminders, prescription adherence programs, or health coaching. Furthermore, Proposers must disclose and certify that no financial bonuses, commissions, volume rebates, or third-party financial incentives are received or paid to TPA staff or subcontractors based on the volume or frequency of direct member contacts or clinical interventions.

No optional member outreach or care management programs may be introduced, implemented, or added to the scope of services after contract award without prior authorization and formal execution of a contract amendment by the City's governing authority.

Each optional service must be priced separately.

4.6 Performance Guarantees & Fees at Risk

a) Performance guarantees
b) Associated financial penalties or fees-at-risk
c) Methodology for calculating penalties
d) Annual reconciliation process
e) Core Performance Guarantees

4.6.1 Performance Guarantees and Fees at Risk

The selected Proposer must agree to the City’s mandatory Performance Guarantees (PGs) outlined in this section.

Total Fees at Risk: The Proposer must place a minimum of 15% of their total annual administrative fees (Per Employee Per Month charges) at risk. This pool of funds will be allocated across the individual performance metrics detailed below: Claims Payment Accuracy, Claims Processing Speed, Call Center Responsiveness, and Member Inquiry Resolution.

Methodology and Penalties: Penalties will be calculated as a direct percentage of the monthly or annual administrative fee associated with that specific metric. Penalties are cumulative; however, the total penalty assessment across all categories shall not exceed the 15% annual cap.

Reporting and Annual Reconciliation Process: The Proposer shall submit quarterly performance tracking reports and a comprehensive performance monitoring report within 60 calendar days following the close of each plan year. All performance calculations must be backed by verifiable operational data.

Remittance of Penalties: If the Proposer fails to meet any established benchmark, the corresponding penalty amount must be issued to the City as a direct financial credit

against the next scheduled administrative invoice, or paid via check within 30 days of the final reconciliation if the agreement is terminated.

Audit Rights: The City reserves the right to audit the Proposer's self-reported performance data using an independent third-party auditor.

No "Gains Sharing": Outperforming a benchmark in one category (e.g., answering calls faster than required) cannot be used to offset or excuse a failure to meet a benchmark in another category (e.g., missing a claims accuracy target).

4.6.2. Claims Processing Accuracy and Timeliness

Financial Accuracy: * Benchmark: 98.0% or higher.

Definition: The total correct dollar amount paid divided by the total dollar amount processed.

Payment Accuracy: * Benchmark: 95% or higher.

Definition: The number of claims processed without an error divided by the total number of claims processed.

Claims Processing Timeliness: * Benchmark: 90% of all clean claims must be resolved within 14 calendar days; 95.0% within 30 calendar days.

4.6.3 Customer Service Performance

a) Average Speed of Answer (ASA): * Benchmark: 30 seconds or less.
b) Abandonment Rate: * Benchmark: Less than 3.0% of all incoming calls are dropped before being answered.
c) First-Call Resolution: * Benchmark: 95.0% or higher.

Definition: Member inquiries are fully resolved during the initial contact, with no repeat contact regarding the same underlying issue within thirty (30) calendar days.

4.6.4 Account Management and Reporting

Reliable data and responsive support to manage the City's budget.

Implementation Timeliness: * Benchmark: 100% of ID cards delivered to members, systems tested, and eligibility files fully live at least 15 days prior to the plan effective date.

Standard Reporting Delivery: * Benchmark: Standard quarterly utilization and financial reports must be delivered within 30 calendar days following the end of each quarter.

Dedicated Account Support: The Proposer must assign a named primary Account Executive and a designated backup representative to support the City. The account management team shall conduct quarterly strategic utilization and financial review meetings, unless an alternative schedule is expressly requested by the City.

Operational Escalation Protocols: The Proposer must establish an immediate escalation pathway for urgent member access-to-care issues. Urgent eligibility or coverage access issues must be acknowledged within one (1) business day and tracked continuously to full resolution.

4.6.5 Eligibility and Data Integration

ID Card Issuance: * Benchmark: New or replacement ID cards must be mailed within 5 business days of receiving a valid eligibility change file from the City.

Electronic Data Interchange (EDI) Success: * Benchmark: 100% load success rate of weekly enrollment files from the City's HR system within 48 hours of receipt.

Critical Error Correction: The Proposer must ensure the precise and accurate processing of weekly eligibility files. Any critical data errors or discrepancies causing urgent access-to-care issues for a member must be corrected and resolved within two (2) business days of notification by the City.

4.6.6 Pass-Through Costs and Transparency Requirements

Proposer must clearly identify:

A. Mandatory Disclosure:

a) Any pass-through charges
b) Subcontractor fees
c) Printing, mailing, or ID card costs
d) Data interface or file-transfer fees

Any other non-administrative charges

B. Transparency & Governance Rules

The Proposer must provide absolute transparency regarding all non-administrative, subcontractor, and pass-through charges. To ensure the City is receiving competitive, uninflated pricing, the following requirements apply to all proposals

a) Actual Cost Mandate (No Markups): All permitted pass-through costs—including Subcontractor fees, Printing, mailing, or ID card production, and Data interface/file transfer fees—must be billed to the City at actual, net cost. The Proposer is strictly prohibited from applying any administrative markups, handling fees, or profit margins to pass-through expenses. Any volume discounts or rebates received by the Proposer from third-party vendors must be passed directly along to the City.

b) Itemization and Documentation: The Proposer must list each anticipated pass-through charge as a separate, distinct line item. For all billing cycles during the contract term, the selected Proposer must attach copies of the original third-party vendor invoices to the City's monthly billing statement to substantiate the exact costs incurred.

c) Prior Written Approval: The selected Proposer shall not incur or bill the City for any new, supplemental, or unlisted pass-through or non-administrative charge without obtaining express, prior written authorization from the City's governing authority. Unapproved pass-through charges will not be honored or paid.

d) Data Interface and File Caps: All standard data interface setup and routine weekly file transfers (including eligibility updates to the City's HR platforms) must be clearly defined as a fixed flat rate or included in the base administrative fee. Variable or hourly data management fees will be considered non-responsive.

Hidden or undisclosed fees discovered after award may constitute grounds for termination.

4.6.7 Cost Proposal Format

The Cost Proposal must be submitted:

a) In a separate sealed envelope or electronic file labeled "Cost Proposal"
b) Using the City's required pricing template (if provided)
c) With all fees expressed on a PEPM basis, per-service basis, or unit cost basis, as applicable
d) With assumptions clearly stated

Note: Incomplete or non-itemized pricing may result in disqualification.

Implementation and Open Enrollment

Implementation Manager: Assign a named implementation manager within five business days after notice of intent to award.

Implementation Timeline: Provide a detailed implementation timeline within ten business days after notice of intent to award.

Open Enrollment Support: Attend open-enrollment meetings, benefits fairs, webinars, and departmental meetings as requested by the City.

Member Communications: Provide customized employee communications, benefit summaries, rate sheets, SBCs, provider search instructions, Rx formulary links, dental network links, and transition-of-care instructions.

Data Integration and Card Issuance: Load eligibility accurately, issue ID cards on time, and provide weekly implementation status reports until coverage is live.

Stakeholder Coordination: Coordinate with the incumbent carrier(s), City payroll, HRIS, broker/consultant if any, COBRA administrator, and Section 125 administrator as requested.

5. City Data Package and Proposer Due Diligence

5.1 Data to Be Provided by the City

The City will make the following historical and administrative data information available to authorized proposers through a controlled data room, secure portal, protected appendices, or other approved process. All protected health information (PHI) and claims information should shall be de-identified in compliance with HIPAA privacy standards, unless a lawful basis and appropriate agreement permit disclosure:

a) **Major Medical Plan Design Documents:** Current medical plan documents, Summaries of Benefits and Coverage (SBCs), benefit summaries, administrative service contracts, and comprehensive renewal history.
b) **Dental:** Current dental plan documents, benefit summaries, utilization, and renewal history.

c) **Enrollment Census:** Complete active Employee and dependent census with including de-identified ZIP codes, age or date of birth, gender if permitted, coverage tier, plan election, employment/retiree status, COBRA status, and eligibility categories.

d) **Medical and Prescription Drug Claims Experience:** Medical/Rx claims experience for at least 24 to 36 months, including paid claims by month, enrollment by month, high-cost claimant summary, (including large claim pooling), diagnosis/category summaries, if available, and historical Rx pharmacy metrics claims, (inclusive of specialty drugs, utilization, and trailing rebates/credits where applicable).

e) **Dental Claims/Utilization Metrics:** Comprehensive dental claims history for at least a minimum 24 to 36 months, including preventive, basic, major, orthodontic service usage categories, if available.

f) **Provider Disruption Files:** or claims De-identified historical provider list for medical, dental, hospitals, pharmacies, and high-utilization providers., de-identified as needed.

g) **Administrative & Payroll Logistics**: Current COBRA/retiree enrollment counts, retiree eligibility rules, collective bargaining or civil service considerations, and payroll deduction timing.

h) **Ancillary and Interacting Programs:** Current wellness, EAP, clinic, telehealth, disease-management, or carve-out programs that interact with medical or dental benefits.

5.2 Proposer Responsibility to Review Data

a) Mandatory Disclosure of Data Deficiencies: Each proposer is responsible for reviewing all RFP materials, addenda, data files, plan documents, and City answers before submitting a proposal. A proposer must identify any missing information that materially affects underwriting or pricing before the question deadline. All such inquiries must be submitted in writing prior to the formal question deadline. Failure to report data deficiencies constitutes a total waiver of the proposer's right to request post-award pricing modifications

b) Prohibition on Post-Award Underwriting Changes: If a proposal relies on assumptions, the assumptions must be clearly stated. Hidden assumptions, undisclosed

contingencies, or post-award underwriting changes may be grounds for rejection or cancellation of award.

c) Rejection of Conditional Bids: The City reserves the right to reject any proposals with material caveats, incomplete rate exhibits, or underwriting contingencies that prevent apples-to-apples comparison.

6. Minimum Proposer Qualifications

At a minimum, each proposer must demonstrate the criteria below. A proposer that cannot meet a requirement must clearly identify the exception and explain the proposed alternative.

The minimum qualifications in this section apply only to the line or lines of coverage for which the proposer is submitting a proposal. At a minimum, each Proposer must demonstrate full compliance with the following mandatory qualifications. A proposer that cannot meet a requirement must clearly identify the exception and explain the proposed alternative. A proposal that fails to meet these baseline standards may be deemed non-responsive and subject to immediate disqualification.

a) **Legal Authority and Mississippi Licensure:** The Proposer must be fully licensed, admitted, certified, and registered with the Mississippi Department of Insurance and the Mississippi Secretary of State to legally operate and provide Third-Party Administration (TPA) and Administrative Services Only (ASO) functions within the State of Mississippi at the time of submission.

b) **Financial Strength and Corporate Stability:** Pure administrative TPAs must submit their most recent audited financial statements, organizational credit ratings, and regulatory status reports to prove long-term operational stability. For fully insured voluntary, employee paid dental and vision plans, proposing insurance carriers must provide current financial strength ratings from at least one recognized rating agency (A.M. Best, Standard & Poor's, Moody's, or Fitch). Proposers without a rating must submit an explicit statement explaining their financial solvency and regulatory standing.

c) **Public Sector and Municipal Experience:** The Proposer must possess a minimum of five (5) years of documented experience managing employee benefit plans (self-funded health plans or fully insured group dental/vision plans) for

governmental, municipal, county, public school district, or similarly complex public-sector employers. Distinct evaluation preference will be granted to proposers who demonstrate extensive experience administering municipal groups of a similar size, budgetary structure, and civil service eligibility complexity.

d) **Local Network Density and Capacity:** The Proposer must possess an established, mature commercial medical, vision and dental provider network with verified access density for City employees, dependents, and retirees residing throughout Jackson, Hinds County, Rankin County, Madison County, and the surrounding municipal areas.

e) **Implementation and Transition Capabilities:** The Proposer must demonstrate the immediate operational capacity to execute a seamless system implementation by the plan's effective date without a single day of coverage lapse. Implementation capacity must include providing dedicated, on-site open enrollment support, custom communication materials, and rapid eligibility file testing.

f) **Regulatory and Statutory Compliance Capacity:** The Proposer must prove they have the automated system capabilities and internal legal infrastructure necessary to support public-sector compliance mandates, including but not limited to: HIPAA privacy/security rules, public-sector COBRA administration, ACA reporting workflows, Summary of Benefits and Coverage (SBC) generation, federal Transparency in Coverage mandates, MHPAEA quantitative testing support, and No Surprises Act (NSA) independent dispute resolution tracking.

g) **Documented Data Security and PHI Safeguards:** Proposers must submit documented evidence of advanced administrative, technical, and physical data safeguards designed to protect confidential municipal data and PHI, maintaining full SOC 2 Type II certification or an equivalent national cybersecurity framework data standard.

h) **Public-Sector Performance References:** The Proposer must provide at least three (3) active, verifiable public-sector or large-employer client references for whom the proposer currently provides comparable self-funded TPA administrative services. References must include the client’s name, group size, contract duration, and a direct administrative contact person. (Note Proposer must complete

Attachment C – References to satisfy all client reference submission requirements).

i) **Corporate Good Standing:** The Proposer must be in verified Good Standing with the Mississippi Secretary of State and explicitly certify that they are not currently subject to any active, unresolved federal or state debarment, corporate suspension, or regulatory cease-and-desist orders that would impair their fiduciary or operational performance for the City.

7. Proposal Submission Instructions

Proposers shall complete only the tabs applicable to the line or lines of coverage they are proposing. Medical requirements apply only to the self-funded medical and prescription drug proposal, dental attachments apply only to the fully insured dental proposal, and vision attachments apply only to the fully insured vision proposal.

7.1 Submission Deadline

Proposals must be received by 3:30 PM, on September 1, 2026. Late proposals will not be accepted. The official time is the time maintained by the City at the submission location or electronic platform.

7.2 Submission Format

Hard Copy Submissions: Proposers must submit one (1) signed original and five (5) full copies in a sealed package, if hard copy submission is required by the City.

Electronic Submissions: Proposers must submit one (1) searchable PDF copy on a USB flash drive or through the approved City electronic submission portal. All financial exhibits, rate schedules, disruption analyses, and pricing models must also be provided in an unlocked, fully functional Excel format.

Package Labeling: Submission packages must be clearly marked on the exterior: *RFP No.* `94828-090126` *- Major Medical, Dental, and Vision Insurance Plans - Do Not Open Until September 01, 2026 3:30 PM*.

Mandatory Completion of Attachments and Questionnaires: Proposers must fully complete and execute all mandatory attachments, questionnaires, pricing schedules, and disruption analysis files provided in the Appendices of this RFP corresponding to their proposed line(s) of coverage (including Medical, Pharmacy, Dental, and Vision

Attachments). Substituting standard carrier marketing materials or failing to complete required RFP exhibits in their native or requested format shall render the proposal non-responsive and subject to immediate rejection.

Binding Period: Proposals must remain firm and binding for a minimum of one hundred twenty (120) calendar days following the proposal submission deadline, unless extended by mutual written agreement.

Confidential Material: Any trade secrets or proprietary material must be placed in a separately labeled envelope/file and accompanied by a written explanation establishing the legal basis for confidentiality under applicable Mississippi public records law. Marking an entire proposal as confidential or proprietary is strictly prohibited and may result in disqualification.

Addenda Acknowledgement: Proposers must formally execute and submit written acknowledgements for all addenda issued by the City. Failure to acknowledge material addenda shall render the proposal non-responsive.

7.3 RFP Administrator and Communication Restriction

All communications about this RFP must be directed only to the Human Resources Director. Proposers may not contact elected officials, City employees, consultants, or evaluation committee members about this procurement except as permitted in writing by the RFP Administrator. Any unauthorized contact may result in immediate disqualification of the Proposer.

7.4 Questions and Addenda

Pre-bid Conference: Attendance at the City of Jackson Pre-Bid Meeting is **mandatory** for all prospective proposers to review RFP requirements, timelines, and submission instructions. Proposers may attend the meeting remotely. To receive the link and instructions for remote access, proposers must contact the designated RFP contact in writing prior to the meeting. Failure to attend the mandatory pre-bid meeting shall render a proposer's submission non-responsive.

Written Questions: All proposer questions or requests for clarification must be submitted in writing to the designated official at least three (3) days prior to the mandatory pre-bid

meeting. The City bears no obligation to respond to inquiries received after this deadline or submitted outside the formal written Q&A process.

Formal Addenda Only: Responses will be issued only by written addendum. No oral statements, telephonic interpretations, electronic mail communications, or other informal representations from any City employee, official, or agent shall be legally binding upon the City or serve to modify the terms of this RFP. Proposers are strictly prohibited from relying upon any external communications, and any such reliance is at the Proposer's sole legal and financial risk.

Administrative Rights: The City reserves the right to issue addenda to clarify, modify, or cancel this RFP. Proposers bear the sole responsibility to actively monitor the procurement portal, secure all issued addenda, and formally execute and attach signed acknowledgements of all addenda within their final proposal submission. Failure to acknowledge issued addenda may result in immediate disqualification.

If an addendum materially alters the scope of services or baseline pricing criteria of the RFP, the City may extend the proposal due date at its sole administrative discretion or as required by law.

8. Proposal Format and Required Content

To facilitate an efficient and objective evaluation process, all proposals must be organized and submitted strictly in accordance with the tab sequence outlined below. Failure to adhere to these structural format instructions or misplacing mandatory documents may result in the immediate disqualification of the proposal.

Use the following tabs and order. Proposals that are organized poorly or omit required sections may lose points or be rejected as nonresponsive.

Tab	Required Content
A. Transmittal Letter	Signed proposal cover sheet; legal name; authorized signer; contact; lines of coverage proposed; acknowledgement of binding period and addenda.

Tab	Required Content
B. Executive Summary	The Proposer must provide a clear executive-level summary, recommended at 1–2 pages, that demonstrates their understanding of the City's needs and their commitment to meeting the RFP's performance expectations. The summary must highlight the Proposer's proposal strengths and present a recommended plan or strategy for eligible employees, eligible retirees, and eligible dependents. It must also identify the key cost drivers that might impact a self-funded medical plan and fully insured dental and vision plans. The Proposer must outline their implementation approach, including major steps and transition support. The summary must also note any deviations from the City's current plans and explain the expected impact of those differences.
C. Minimum Qualifications	The Proposer must demonstrate that they meet all organizational and regulatory qualifications required to administer a self-funded medical plan or a fully-insured dental or vision plan, or both. This includes providing evidence of all required licenses, current Mississippi authorization to operate as a TPA, vision or dental carrier, and up-to-date financial ratings from nationally recognized rating agencies. The Proposer must document relevant public-sector experience administering medical, vision or dental benefits for municipalities or similar governmental entities. The Proposer must supply a comprehensive company background overview and disclose any litigation or regulatory actions within the past ten years that could impact their ability to serve the City. The Proposer must also provide

Tab	Required Content
	evidence of good standing in all jurisdictions in which they operate, confirming their capability to support the City's eligible employees, eligible retirees, and eligible dependents across both medical, vision and dental plan offerings.
D. Medical Plan Proposal	The Proposer, acting as the Third-Party Administrator for the City's self-funded medical plan, must demonstrate how they will ensure delivery of all required plan documentation and administrative components. The Proposer must provide complete and accurate plan designs, a summary of benefits and coverage (SBC), and benefits grids, along with clearly documented deviations from the City's current medical offerings. The Proposer must supply an up-to-date Rx formulary and verify the accuracy of all network information for participating medical providers. The Proposer must describe their utilization management and care management programs, including how these programs support a municipal workforce. The Proposer must outline available telehealth services and detail their member service capabilities, including call center performance standards and municipal-specific support processes. The Proposer must also explain how they will deliver comprehensive reporting for the City's self-funded plan and ensure ongoing compliance support aligned with all applicable federal and state requirements governing public sector health plans.
E. Dental Plan Proposal	The Proposer must provide complete and accurate plan designs, and a summary of benefits and coverage (SBC), along with clearly documented deviations from current

Tab	Required Content
	dental offerings. The Proposer must supply an up-to-date Rx formulary if applicable to dental benefits and verify the accuracy of all network information for participating dental providers. The Proposer must describe their utilization management and care management programs as they apply to dental care, outline available telehealth services for dental consultations, and detail their member service capabilities. The Proposer must also explain how they will deliver comprehensive reporting for the City's dental plan and ensure ongoing compliance support aligned with all applicable federal and state requirements.
F. Vision Plan Proposal	The **Proposer must provide complete and accurate plan designs** for all covered vision benefits, including routine eye exams, lenses, frames, contact lenses, medically necessary contacts, low-vision services, and any specialty lens options. The proposer must also supply a full **Summary of Benefits and Coverage** (SBC). If applicable, the proposer must provide an up-to-date **vision-related formulary** (such as medically necessary contact lens criteria) and verify the accuracy of all **network information** for participating vision providers, including optometrists, ophthalmologists, and retail optical centers. The Proposer must also explain how they will deliver comprehensive reporting for the City's vision plan and ensure ongoing compliance support aligned with all applicable federal and state requirements.

Tab	Required Content
G. Provider Network and Disruption	The Proposer must demonstrate how they will ensure delivery of all required network and access materials for a self-funded medical plan and fully funded vision and dental plan. The Proposer must show that they can produce accurate network access reports for the medical plan and maintain validated, up-to-date hospital and facility access data within the City's service area. The Proposer must also demonstrate their ability to generate current dental provider counts for the fully insured dental network. They must describe how they will conduct a thorough provider disruption analysis based on the City's existing providers. The Proposer must provide functional, regularly updated provider search links for both medical and dental networks. Finally, the Proposer must outline a comprehensive transition-of-care plan that minimizes member disruption during implementation.
H. Pricing and Underwriting	The Proposer must provide complete, transparent, and fully itemized pricing for a self-funded medical plan and fully insured dental and vision plans. Pricing must include all rates, fees, assumptions, commissions, pricing alternatives, rate guarantees, renewal methodology, and all required pricing forms. All cost components must be clearly documented and free of undisclosed or contingent charges.
I. Implementation and Service Team	The Proposer must demonstrate how its implementation and service team will ensure a smooth, well-managed transition and provide dependable ongoing support for the City of Jackson, MS medical and dental plans. The Proposer must clearly show how it will plan and coordinate all setup

Tab	Required Content
	activities—including eligibility file integration, claims system configuration, network activation, and verification of benefits and member data—while working with City departments to minimize disruption for employees, retirees, and dependents. The Proposer must also demonstrate how its service team will function as the City's primary support structure by managing the account, maintaining service levels, providing defined points of contact, applying an escalation matrix for timely issue resolution, supporting open enrollment as needed, and delivering communication materials that help members understand their benefits.
J. Compliance and Data Security	The Proposer must demonstrate how they will maintain full compliance with HIPAA, ensure the use of secure data-transmission protocols, execute and uphold a Business Associate Agreement, implement and document robust cybersecurity controls, and report any data breaches in accordance with all applicable federal and state laws.
K. References	Proposers must provide at least three (3) references from public-sector clients, preferably municipal, county, or state government entities located in the Southeast region of the United States. Each reference must reflect work performed as a Third-Party Administrator or health-plan services provider within the past five (5) years and must demonstrate experience administering self-funded medical plans and fully-insured vision and dental plans of comparable size, complexity, and workforce composition to the City of Jackson.

Tab	Required Content
	References must include the client's organization name, contract period, scope of services provided, population served, and current contact information for a knowledgeable representative who can speak to the Proposer's performance, service quality, responsiveness, and compliance history.
L. Exceptions	The Proposer must clearly disclose and describe any contract exceptions, RFP deviations, benefit deviations, underwriting contingencies, legal term exceptions, or proposed alternative language included in its proposal. For each exception, the Proposer must provide the rationale for the requested change and outline any associated operational, financial, or contractual impact on the City of Jackson, MS.
M. Required Forms	The Proposer must submit all required documentation associated with this RFP, including required certifications, forms, attachments, and signatures necessary for a complete and compliant proposal, ensuring that each item is fully executed, accurate, and submitted in the format prescribed by the RFP.

8.1 Proposal Completeness Rules

Direct Responses Required: Proposers must directly answer each question and complete every form. Attaching standard marketing brochures or generic proposals in lieu of direct responses is strictly prohibited and may result in disqualification.

Itemized Status Requirements: For each required item or benefit feature, Proposers must state on of the following statuses and provide a detailed explanation for each exception:

a) Included
b) Not included
c) Included with exception
d) Not applicable

Rate Guarantees & Conditions: Clearly Identify the underwriting and binding status of each proposed rate. Every rate must be categorized as one of the following:

a) guaranteed
b) illustrative,
c) subject to underwriting,
d) subject to enrollment,
e) or contingent on participation.

Service Cost Structure: Identify the funding structure for each proposed service. Every service must be explicitly categorized under one of the following designations:

a) included in premium,
b) included in administrative fees,
c) optional for an additional fee,
d) or not available.

9. Pricing Instructions

Pricing must be transparent, fully itemized, and suitable for public procurement evaluation. Pricing must be separated by line of coverage and by funding structure. Self-funded medical pricing shall be stated separately from fully insured dental and fully insured vision premium pricing. The City reserves the right to reject any proposals that do not disclose the full cost of coverage and administration.

a) **Tiered Rate Structure:** Provide monthly rates by coverage tiers: Employee Only, Employee Plus One, Employee Plus Family. If the proposer uses different tiers, they must provide a detailed tier crosswalk and supporting actuarial explanation.
b) **Annualized Cost Projection**: Provide total projected annual cost using the City's current census. Show the formula, enrollment counts, rates, and annualized amounts.
c) **Full Compensation & Fee Disclosure**: Disclose commissions, overrides, bonuses, producer compensation, consultant allowances, pharmacy revenue,

rebates retained, network access fees, implementation fees, banking fees, COBRA fees, run-out fees, and any other compensation or cost passed to the City or plan participants.

d) **Commission Structure Variations:** Provide ASO fee and stop loss premium quotes with and without broker/agent commissions if commissions are included or available. Proposers must provide premium quotes both inclusive of broker/agent commissions and completely net of commissions (fee-only) to allow the City to evaluate the true baseline cost of the coverage.

e) **Participation & Contribution Thresholds:** State minimum participation percentage of employees required to enroll to establish contract, maintain the contract coverage and guarantee the quoted rates.

f) **Rate Guarantees & Volatility:**

(1) For Self-Funded Medical (TPA Proposers) State administrative guarantees (e.g. 24-month or 36-month guarantees), the renewal methodology for subsequent years, and the specific circumstances under which ASO fees or administrative factors can change before or during the plan year.

(2) For fully insured Dental and Vision (Carrier Proposers) (Dental/Vision): State the fully insured premium rate guarantees (e.g., 24-month or 36-month guarantee), the renewal methodology for subsequent years, and the specific circumstances under which premium rates can change before or during the plan year.

Alternative Plan Cost Increments:

(1) Medical ASO, For alternative self-funded plans proposed, show incremental savings or/costs to fixed fees or projected claims compared to the closest current plan match. (2) Dental/Vision: If alternative fully insured plan designs are proposed outside of the primary requested design, the Proposer must clearly outline the premium rate differences and benefit modifications compared to their primary proposal.

(g) **Self-funded/ASO Cost Component Split (Medical ASO):** For self-funded/ASO alternatives, separate fixed costs, expected claims, maximum claims, stop-loss

premium, aggregate attachment point, run-out, reserves, taxes/fees, and worst-case liability.

9.1 Cost Proposals and Premium Rate Tables

The Proposer must complete the applicable rate tables below for all proposed plan designs. Rates and fees must remain guaranteed for the duration specified in the Proposer's rate guarantee statement. For all voluntary, employee-paid benefits (Dental and Vision), the City's municipal contribution is strictly $0.00, and the Total Monthly Premium must equal the Monthly Employee Premium.

Proposers shall complete the applicable rate tables only for the line or lines of coverage they propose. Medical rates and fees shall be shown separately from dental and vision premiums.

Line	Tier	Current Enrollment	Monthly Rate	Annual Cost	Notes / Assumptions
Medical Plan 1	Employee Only	**845**	$	$	
Medical Plan 1	Employee + 1	**251**	$	$	
Medical Plan 1	Employee + Family	**154**	$	$	
Dental Plan 1	Employee Only	**781**	$	$	
Dental Plan 1	Employee + 1	**225**	$	$	
Dental Plan 1	Employee + Family	**195**	$	$	
Vision Plan 1	Employee Only	Not Available	$	$	
Vision Plan 1	Employee + 1	Not Available	$	$	

Vision Plan 1	Employee + Family	Not Available	$	$

10. Evaluation and Award

10.1 Evaluation Committee

The City may appoint an evaluation committee made up of representatives from Human Resources, Finance, Legal, Purchasing, Administration, employee-benefits stakeholders, and/or outside advisors. The City may require committee members to sign a conflict-of-interest/confidentiality acknowledgement before reviewing proposals.

10.2 Evaluation Criteria

The City will evaluate responsive proposals using the criteria in Track A (Medical), Track B (Dental) and/or Track C (Vision). The City may also evaluate bundled proposals if bundling is expressly permitted in the solicitation. The evaluation will be based only on the criteria stated in this RFP and any written addenda.

Track A: Self-Funded Major Medical Services (100 Points Total)

Criteria	Weight	What the City Will Consider
Price / Total Projected Cost	45 points	Premiums, fees, projected annual cost, employee cost impact, rate guarantees, renewal risk, commissions, administrative fees, stop-loss if applicable, and total value.
Network Access and Provider Disruption	25 points	Medical, hospital, pharmacy, behavioral health, specialist, network strength; disruption analysis; local access; transition-of-care support.
Plan Design and Member Impact	15 points	Match to current benefits, covered services, Rx formulary, alternatives, member disruption, plan clarity, and communication quality.

Administration, Service, and Implementation	10 points	Implementation plan, open-enrollment support, account team, member service, eligibility administration, reporting, claims handling, escalation, and performance standards.
Compliance, Financial Strength, and Public-Sector Experience	5 points	Mississippi authorization, financial strength, regulatory history, data security, public-sector references, legal compliance support, and contract acceptability.
Total	**100 points**	**Highest scoring proposal is not automatically guaranteed award; final award is subject to City determination, negotiations, and governing authority approval.**

Track B: Fully-Insured Dental Services (100 Points Total)

Criteria	Weight	What the City Will Consider
Price / Total Projected Plan Cost	40 points	Total monthly premium costs across all three coverage tiers, the length of the initial rate guaranteed period (e.g. 24 versus 36 months), and the transparency/cap of the renewal methodology. Dental ASO administrative fees, projected annual dental claims cost based on actuarial data, administrative fee guarantees, and total expected plan financial value. (Note: Stop-loss is rarely purchased for dental due to low maximum annual caps, but any proposed aggregate limits would be reviewed here).

Dental Network & Access	40 points	Dental provider network strength (general practitioners and specialists), local provider access within Mississippi, and dental provider disruption analysis.
Plan Design & Administration	20 points	Match or enhance current dental plan designs, covered services, deductibles, and annual maximums. Assesses administrative capabilities, including account management, claims adjudication accuracy and processing turnaround, eligibility maintenance, customer service standards, online member tools, and employee communication support.
Total	**100 points**	**Highest scoring proposal is not automatically guaranteed award; final award is subject to City determination, negotiations, and governing authority approval**

Track C: Fully-Insured Vision Services (100 Points Total)

Criteria	Weight	What the City Will Consider
Price / Total Projected Plan Cost	40 points	Overall financial competitiveness and cost predictability of the proposal. Assesses premium rates, fee guarantees, administrative costs, operational expenses, claim projections, renewal rate caps, and any proposed fee structures or financial performance guarantees over the contract term.
Vision Network & Access	40 points	Vision provider network strength (general practitioners and specialists), local provider access within Mississippi, and vision provider disruption analysis.

Plan Design & Administration	20 points	Propose comprehensive plan designs, covered services, lens/frame allowances, copay structures, and provider networks for newly offered vision coverage (as the City does not currently offer a standalone vision plan). Assesses administrative capabilities, including account management, claims adjudication accuracy and processing turnaround, eligibility maintenance, customer service standards, online member tools, and employee communication support.
Total	**100 points**	**Highest scoring proposal is not automatically guaranteed award; final award is subject to City determination, negotiations, and governing authority approval.**

10.3 Evaluation Process

a) **Initial Administrative Review**: Administrative review for timeliness, signatures, addenda acknowledgement, required forms, and minimum responsiveness.

b) **Technical Review:** Technical review of plan designs, networks, services, compliance, and implementation ability.

c) **Financial Review:** The City will conduct a rigorous financial analysis tailored to the proposed funding mechanism:

d) **For Self-Insured Proposals:** review of ASO fees, stop loss premiums, aggregated attachment points, and actuarial claim projections;

e) **For Fully Insured Proposals**: Evaluation of tiered monthly premium rates, multi-year rate caps, and total projected cost, underwriting assumptions, commissions, fees, and renewal risk variables.

f) **Background and Credential Verification:** The evaluation will include reference checks, Mississippi licensing/authorization review, independent financial strength rating reviews (e.g., A.M. Best), and contract exception review.

g) **Finalist Engagements:** At the City's sole discretion, top-scoring finalist may be invited for Interviews, presentations, technical clarifications, or the submission of a Best and Final Offer (BAFO), if the City determines they are useful.
h) **Formal Recommendation:** The evaluation committee will draft a formal written award recommendation with scoring summary and a narrative rationale.
i) **Governing Authority & Execution:** The final approval is contingent upon formal approval by the City's governing authority, followed by contract/policy execution by authorized City officials.

10.4 Lowest and Best / Most Advantageous Award

The City intends to award the contract to the proposer whose proposal is determined to be the lowest and best and/or most advantageous to the City based on the published evaluation criteria. Cost will be considered but will not be the sole determining factor, and the City may evaluate overall value, including service, implementation, network adequacy, and total cost and risk.

10.5 City Reservations

The City explicitly reserves the right to take any of the following actions when it is determined to be in the City's best interest:

a) **Reject Proposals:** Reject any or all proposals.
b) **Waive Irregularities:** Waive immaterial informalities or minor irregularities.
c) **Request Engagements:** Request clarifications, additional information, interviews, finalist presentations, or best and final offers.
d) **Conduct Negotiations:** Negotiate plan design, rates, fees, contract terms, implementation items, or service levels with one or more proposers.
e) **Separate or Combined Awards:** Award medical and dental separately or together.
f) **Split/Multiple Awards:** Award to multiple proposers if doing so is in the City's best interest.
g) **RFP Modifications**: Cancel, amend, postpone, or reissue the RFP.
h) **Decline to Award:** Decline to award if pricing, terms, or coverage do not meet the City's needs.

11. Contract Term and Renewal

Initial Term: The initial contract/policy term will be **January 1, 2027 – December 31, 2027**, unless otherwise approved by the City.

Prohibition on Automatic Renewals: No automatic renewal, evergreen provision, or rate change is binding unless approved by the City in writing through is authorized governing process.

Multi-Year Extensions: The City may request renewal options for up to four additional one-year periods, subject to satisfactory performance, acceptable renewal pricing, budget availability, applicable law, and governing authority approval. Any renewal, extension, or multi-year term is subject to all applicable Mississippi public purchasing requirements and City approval procedures.

Rate Guarantees: Proposers must state the guaranteed rate period for each plan and line of coverage.

Renewal Notice: Renewal proposals must be provided no later than 120 days before the next plan year unless the City agrees otherwise in writing.

City Reservation of Rights: The City reserves the right to re-solicit, negotiate renewals, modify plan design, add or remove coverage lines, or terminate at the end of any plan year.

12. General Terms and Conditions

12.1 No Binding Contract Until Approval

No proposer acquires any right or claim against the City unless and until a written contract, policy, or agreement is formally approved by the governing authority and executed by authorized City officials.

12.2 Applicable Law and Venue

The solicitation and any resulting contract will be governed by applicable federal law, Mississippi law, and City requirements. Venue for all legal disputes must be in a court of competent jurisdiction serving Hinds County, Mississippi, unless otherwise strictly required by law.

12.3 Subject to Appropriation

Any financial obligation of the City is explicitly subject to budget approval and lawful municipal appropriation. The City will not agree to an unlawful debt, penalty, or indemnity.

12.4 No Waiver of Immunity

Nothing in the RFP or resulting contract will be construed as an intentional, implied, or explicit waiver of any governmental, statutory, or sovereign immunity available to the City.

12.5 Indemnification

The City will not provide broad indemnification to a proposer. Any indemnity must be lawful under Mississippi municipal law, limited, mutual if appropriate, and approved by the City Attorney.

12.6 Records and Audit

The selected Proposer must maintain complete and accurate records relating to the contract and make all records available for lawful audit, regulatory review, and City review, subject to applicable privacy laws and confidentiality requirements.

12.7 Public Records

Proposals and contracts may be deemed public records under Mississippi law. Proposers must not submit unnecessary confidential information and must strictly follow this RFP's confidentiality instruction.

12.8 Assignment

No assignment, transfer, subcontracting of material services, or change in key service providers may occur without prior written City approval, except as expressly allowed in the final contract.

12.9 Subcontractors

The Proposer remains solely responsible for all subcontractors, Pharmacy Benefit Managers (PBMs), network vendors, data vendors, implementation vendors, and service partners. Proposers must explicitly identify all material subcontractors within their proposal.

12.10 Conflict of Interest

Proposers must disclose any actual, potential, or perceived conflict of interest, including relationships with City officials, employees, consultants, brokers, or evaluation participants.

12.11 No Gratuities / No Contingent Fees

Proposers must not offer gifts, gratuities, campaign contributions tied to this procurement, or contingent payments intended to influence the award.

12.12 Non-Discrimination

The selected Proposer must comply with all applicable non-discrimination and equal employment opportunity laws.

12.13 Taxes, Licenses, and Fees

The Proposer is solely responsible for all licenses, permits, taxes, assessments, surcharges, and regulatory fees applicable to the Proposer's performance, unless expressly identified as a City cost in the proposal and accepted by the City.

12.14 Governing Plan Documents Control

For fully insured benefits (e.g., dental), the final policy or certificate terms govern covered benefits. For self-insured benefits, the final ASO Agreement, stop-loss policy, or approved Plan Document governs operations. In all instances, the Proposer must not materially reduce promised RFP benefits or fee caps without written City approval.

12.15 Termination

The City reserves the right to require termination rights for convenience, non-appropriation, default, material regulatory issues, loss of licensure, data breaches, failure to perform, or unacceptable renewal terms.

12.16 Transition Assistance

Upon termination or non-renewal, the selected Proposer must fully cooperate in an orderly transition. This includes the timely transfer of claims run-out files, eligibility history, historical reporting, plan documents, and legally permissible data transfers.

12.17 Order of Precedence

The final contract will explicitly state the order of precedence among the contract, policies, ASO agreements, the RFP, written addenda, the proposer's proposal, pricing exhibits, Business Associate Agreements (BAAs), and service level agreements. In the event of any conflict among the RFP, addenda, proposal, contract, plan document, insurance policy, or other attachments, the order of precedence shall be as stated in the final executed contract. If no order of precedence is stated, the final executed contract and the governing authority's written approval shall control over all prior drafts and proposal materials.

12.18 Business Associate Agreement Mandate

Prior to the release or transmission of any Protected Health Information (PHI), the selected Proposer must execute a City-approved Business Associate Agreement (BAA) in full compliance with federal HIPAA privacy and security regulations and Section 13 of this RFP.

12.19 Fiduciary Status (Medical Only)

For self-insured medical administration, the selected Proposer explicitly acknowledges its role as a claims administrator and agrees to exercise its discretionary authority in the review and adjudication of member claims with the highest standard of care, compliance, and fiduciary responsibility.

13. Compliance, Privacy, and Data Security

13.1 Legal Compliance

Proposers must comply with all laws applicable to the coverage and services proposed. Proposers must indicate their operational capacity to fulfill the legal and compliance obligations listed below. The City's baseline compliance expectations are designated in the matrix; Proposers must confirm compliance or explicitly detail any proposed division of responsibility in their response:

Compliance / Statutory Mandate	Proposer	City	Shared
a) Mississippi Licensure & TPA Status	X		
b) Affordable Care Act (ACA) Reporting & SBCs	X		

c) HIPAA Privacy, Security, & BAAs	X		
d) COBRA Continuation Administration	X		
e) Mental Health Parity (MHPAEA) Data & Analysis	X		
f) No Surprises Act (NSA) & IDR Claims Handling	X		
g) Transparency in Coverage Machine-Readable Files	X		
h) Mandated Plan Notices (WHCRA, CHIPRA, etc.)	X		
i) Section 125 Cafeteria Plan & Enrollment Files			X

13.2 Data Security and Confidentiality

Requirement	Expected Response
Security Program	Describe information security governance, policies, risk assessment, access controls, encryption, vulnerability management, incident response, and employee training.
PHI / PII Protection	Describe HIPAA safeguards, role-based access, minimum necessary procedures, secure file transfer, retention/destruction, and offshore access restrictions, if any.
Business Associate Agreement	State whether proposer will sign the City's BAA or provide proposer's standard BAA. Explain any exceptions.
Data Breach	State breach notification timelines, investigation process, mitigation, credit monitoring if applicable, and cooperation obligations.

Requirement	Expected Response
Subcontractors	Identify material subcontractors with access to City data and describe oversight, security requirements, and flow-down obligations.
Audit Reports	Provide SOC 2, HITRUST, ISO, or other security audit summaries if available, or explain why not available.
Data Ownership	Confirm City ownership of City data and plan data to the extent permitted by law and contract.
Data Return / Destruction	Describe process for returning or destroying City data at contract end, subject to legal retention and claims administration needs.

13.3 Public Records and Confidential Information

Proposals submitted to the City are subject to the Mississippi Public Records Act. Proposers should not assume that material is confidential merely because it is marked confidential. The City will make public-records determinations in accordance with applicable law.

- Place any claimed confidential trade-secret or proprietary commercial/financial material in a separate clearly labeled section.
- For each claimed confidential item, identify the specific legal basis for confidentiality and explain the harm from disclosure.
- Do not mark the entire proposal confidential.
- Pricing, total cost, contract terms, and awarded contract information may be subject to disclosure as public records.
- The proposer is responsible for defending any confidentiality claim to the extent required by law and City process.

14. Attachments and Required Forms

All required forms, certifications, exhibits, pricing tables, network reports, exception forms, and acknowledgments are listed in this section. Proposers must complete all required attachments applicable to the line or lines of coverage proposed. The attachments to this RFP are made a part of this RFP as if copied herein in words and figures.

ATTACHMENT A - Proposal Cover Sheet

Field	Response
Legal Name of Proposer	
Doing Business As	
Address (Home Office)	
Primary Contact / Title	
Email / Phone/Fax	
Entity Type	[Carrier / / Dental Carrier / Vision Carrier/TPA / ASO / Stop-Loss / Other]
Mississippi License or Authorization No.	
Federal Tax ID	
Lines Proposed	[Medical / Rx / Dental / Vision/ ASO / Stop-Loss / Other]
Addenda Acknowledged	List all addenda
Proposal Binding Period	At least 120 days

Authorized Attestation

By signing below, the undersigned certifies that all information provided in this proposal is accurate, true, and binding upon the proposing entity in accordance with the terms of this RFP.

Signature: _____

Printed Name and Title: _____Date: _____

ATTACHMENT A – 1 General Information:

1. Company name and address of home office.
2. Most recent audited financial statement and SSAE 16 audit (type I or 2) report.
3. Organizational chart including the names and titles of key personnel responsible for the services to be provided to the City of Jackson under this proposal.
4. Number of employer sponsored health plans and total covered subscribers under an administrative service agreement with your company.
5. Number of employer sponsored health plans and total covered subscribers under contract with your company in Jackson, Hinds County, Rankin County, Madison County and surrounding counties.
6. List of three references from clients with plans that have at least 500 enrolled subscribers; two of which must be located in Mississippi. Include the number of covered subscribers, services provided and duration of the relationship. Also provide the name, address, phone number and e-mail address of the official who should be contacted. (Note: If Proposer has completed Attachment C: References). Proposer may satisfy this requirement by cross-referencing Attachment C here.)
7. Sample contract(s) for review by the City's legal department.
8. Proof of professional liability and errors and omissions insurance.
9. List of reinsurance carriers that have approved the firm as a claims payment administrator and if there are any preferred rating arrangements.
10. Any additional information concerning the proposer's ability to perform, financial strength or client base.

ATTACHMENT B - Required Certifications

Authority to Submit Proposal. The signer certifies that he or she is authorized to bind the proposer and submit this proposal.

Non-Collusion. The proposer certifies that the proposal is genuine, not collusive or sham, and not made in the interest of or on behalf of any undisclosed person or entity.

No Improper Influence. The proposer certifies that it has not offered gifts, gratuities, or anything of value to influence this procurement.

Conflict Disclosure. The proposer certifies that all actual, potential, or perceived conflicts of interest have been disclosed.

Licensing and Good Standing. The proposer certifies that it is legally authorized to provide the proposed services in Mississippi and will maintain all required licenses and approvals during the contract term.

RFP Review. The proposer certifies that it has reviewed the RFP, addenda, data package, and all required forms and has identified all exceptions in writing.

Confidentiality. The proposer agrees to comply with all confidentiality, data security, HIPAA, and public-records requirements applicable to the proposal and any resulting contract.

Signature _____

Title _____

(SEAL)

Sworn before me this _____ day of _____, 20 ___,

_____, Notary Pubic

ATTACHMENT C – References:

List three references from clients with plans that have at least 500 enrolled subscribers; two of which must be located in Mississippi. Include the number of covered subscribers, services provided and duration of the relationship. Also provide the name, address, phone number and e-mail address of the official who should be contacted.

Reference	Organization	Contact Name/Title	Email/Phone	Coverage/Services Provided	Group Size	Years Served
1						
2						
3						

ATTACHMENT D - Exceptions and Deviations Form

Item No.	RFP Section / Requirement	Exception or Deviation	Proposer's Proposed Alternative	Cost / Risk Impact
1				
2				
3				
4				
5				
6				
7				

If no exceptions are taken, proposer must state: "No exceptions." The City may reject proposals with unacceptable exceptions.

Attachment E - Medical and Prescription Drug Proposal Questionnaire

1. Identify the legal entity underwriting the medical coverage and the entity administering claims.
2. Does the Proposer have an office in the Jackson, MS metropolitan area?
3. Confirm whether the proposal is fully insured, level-funded, self-funded/ASO, or an alternative arrangement. Provision and distribution of a Summary of Benefits and Coverage (SBC) and Uniform Glossary which accurately describe the rules and benefits of the Health Plan in the format required by the Affordable Care Act.
4. Identify every benefit deviation from the City's current medical/Rx plan.
5. Describe the medical network, hospital network, behavioral health network, pharmacy network, and service area.
6. Provide provider disruption results using the City's claims/provider file, including in-network match rates by provider type.
7. Identify network facilities in Jackson, Hinds County, Rankin County, Madison County, and surrounding counties.
8. Describe transition-of-care procedures for ongoing treatment, pregnancy, surgery, specialty medications, behavioral health, and high-cost claimants.
9. Describe prior authorization, concurrent review, case management, disease management, wellness, telehealth, and nurse-line services.
10. Describe Rx formulary, specialty pharmacy, rebates/credits, prior authorization, step therapy, exclusions, and member communications for drug changes.
11. Identify all fees, commissions, overrides, bonuses, retained rebates, and other compensation.
12. Describe member customer service, dedicated phone line if any, web/mobile tools, language support, and escalation process.
13. Provide claims processing statistics, appeals statistics, complaint statistics, and regulatory actions for the last three years, if available.
14. Describe employer reporting, renewal reporting, utilization reporting, and sample reports.
15. State minimum participation and contribution requirement.
16. State rate guarantees and renewal methodology.

17. Please confirm your ability to provide the following materials and administrative services, and describe your standard turnaround times or processes for each:
    a. Claims & Payments: Processing and mailing checks and Explanations of Benefits (EOBs) to both subscribers and providers.
    b. Member Identification: Production and issuance of standard claim forms and member ID cards.
    c. Customer Support: Dedicated toll-free customer service line for City of Jackson members.
    d. Enrollment & Educational Materials: Custom or standard brochures for open enrollment and new hires explaining network access, provider directories, and FAQs.

18. Regulatory Compliance & Certification:
    a) Compliance Support: Describe your organization's support and administrative processes for the following requirements:
        1. Legal notices & Summary of Benefits and Coverage (SBCs)
        2. Machine-readable files (Transparency in Coverage)
        3. No Surprises Act compliance
        4. Mental Health Parity and Addiction Equity Act (MHPAEA) compliance
    b) COBRA administration

        HIPAA / HITECH Certification: Please confirm and certify that your organization will perform all facets of plan administration in accordance with HIPAA and HITECH standards.

19. Identify subcontractors including PBM, behavioral health telehealth vendor, network vendor, care management vendor, or data vendor.

20. Provide any recommended plan design changes for cost control and quantify the expected impact.

21. Provider Disruption Analysis: Utilizing the City's provided provider/claims file, execute and attach a comprehensive provider disruption analysis. State the exact percentage match rates for:

a) Primary Care Physicians (PCPs)
b) Specialists
c) Acute Care General Hospitals
d) Behavioral Health Providers

22. Transition and Continuity of Care: Detail your operational policies for Transition of Care/Continuity of Care for transitioning members. Address specific protocols, clinical timelines, and extended network coverages for:

a) Ongoing acute treatments (e.g., oncology, dialysis)
b) Third-trimester pregnancies
c) Scheduled inbound surgeries
d) Active behavioral health courses
e) Specialty medication stability
f) High-cost claimants

23. Medical Management Infrastructure: Describe your comprehensive clinical management programs. Detail your processes for prior authorizations, concurrent inpatient reviews, acute case management, chronic disease management, wellness initiatives, telehealth capabilities, and 24/7 nurse-line access.

24. Pharmacy Benefit Management (PBM) Administration: Detail your prescription drug administration protocols, including:

Formulary structure (Open, Managed, Closed) and current tier configurations.

Specialty pharmacy delivery models, sourcing channels, and cost-containment rules.

Prior authorization, step-therapy, and clinical quantity exclusion rules.

Member disruption communication plans for mid-year formulary changes.

[For Self-Funded/TPA]: Define your drug rebate transparency model, including the exact percentage of manufacturer rebates passed through to the City versus any amount retained by the Proposer/PBM.

IV. Financial Terms, Fees, and Rate Structuring

25. Total Compensation Transparency: Disclose and itemize all administrative fees, monthly premium rates, level-funded fixed costs, commissions, broker overrides,

volume bonuses, retained PBM spread pricing, or any alternative revenue sources tied to this contract.

26. Financial Risk and Stability: * [For Fully Insured]: State your pooling point threshold, multi-year rate cap guarantees, and your exact premium renewal calculation methodology.

[For Self-Funded/TPA]: State your fixed per-employee-per-month (PEPM) ASO administrative fee guarantees, contract run-out provisions, and your integration capabilities with independent stop-loss/excess risk insurance carriers.

27. Participation and Contributions: State your absolute minimum employer contribution percentages and employee enrollment participation requirements necessary to secure the proposed financial terms.

V. Operational Administration and Member Services

28. Customer Service Delivery: Describe your member customer service infrastructure. Confirm whether the City will receive a dedicated member phone line, and detail your online web portals, mobile application capabilities, multi-lingual translation support, and formal claims grievance/escalation paths.

29. Performance Metrics and Statistics: Provide your organization’s national or book-of-business averages for the last three (3) fiscal years regarding:

First-pass claims processing accuracy rates

Average speed of answer (ASA) and abandonment rates

Formal member appeal and complaint statistics

Any material state or federal regulatory sanctions/actions

30. Data Reporting and Analytics: Describe your standard employer reporting packages. Provide a list of available utilization reports, renewal underwriting packages, claims spend trackers, and attach a sample standard reporting dashboard.

VI. Implementation, Subcontracting, and Compliance Support

31. Implementation & Open Enrollment: Provide a detailed transition timeline assuming an effective date of [Insert Effective Date]. Address file testing timelines, physical ID card distribution schedules, and your plan for on-site/virtual open enrollment support.

32. Core Subcontracting Disclosures: Explicitly identify all material third-party subcontractors, corporate affiliates, or outsourced business units utilized to fulfill this proposal, including but not limited to: independent PBMs, standalone behavioral health networks, separate telehealth platforms, care management vendors, or data clearinghouses.

33. Compliance and Statutory Mandates: Confirm your organization's capacity to support, execute, or supply compliance data for the following group health plan requirements:

a) Summary of Benefits and Coverage (SBC) generation
b) No Surprises Act (NSA) compliance and IDR management
c) Mental Health Parity (MHPAEA) NQTL testing and comparative data support

Transparency in Coverage (TIC) public machine-readable file (MRF) hosting

COBRA administrative notification fulfillment

34. Strategic Plan Design Recommendations: Identify any recommended, alternative plan design modifications or clinical programs that could generate immediate or long-term cost controls for the City. Actuarially quantify the expected dollar or premium impact of each recommendation.

35. Benefit Deviations: Any proposed deviation, exception, or modification to the City's current medical and prescription drug plan designs must be explicitly detailed and justified on **[Attachment D: Plan Deviations]**. Proposers shall not submit deviations within narrative text alone,

Attachment E-1 – Administrative Services

The following administrative services should be included in your proposed administrative fee. Any service that cannot be performed should be listed with an explanation of why the service is not available or an alternative service that will provide the same or better result. Provide any information that is requested on a specific administrative process.

1. Administration of the PPO networks including provider contracts, communication plan provisions, quality of care review and assurance, and review of utilization and cost effectiveness.

2. Maintenance of eligibility in accordance with the Plan's eligibility rules and verification of eligibility information with the City's Department of Human Resources.

3. Payment of all benefits in accord with the Plan provisions and all required governmental reporting.

4. Provision of all materials required for administration including: checks, explanation of benefits (EOB) to the subscriber and provider, toll free customer service telephone line, claim forms and ID cards, and a brochure to be used during open enrollment and for new hires which describes specifically your network including information on accessing network providers and answers to commonly asked questions.

5. Electronic management of eligibility reports and claim status available on-line.

6. Assistance with the development of the summary plan description (SPD) and employee communications, including printing, distribution and listing on a web site.

7. Provision and distribution of Summary of Benefits and Coverage (SBC) and Uniform Glossary which accurately describe the rules and benefits of the Health Plan in the format required by the Affordable Care Act.

8. Certification to the City that your organization will perform all facets of administration in accordance with Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology and Clinical Health Act (HITECH).

9. Certification to the City that your organization will provide all government reporting such as the Medicare reporting required by CMS of covered members, by Social Security number, name, and type of coverage.

10. Certification of the City's prescription drug benefit for creditable coverage under the Medicare Part D provisions.

11. Assistance with ACA compliance including provision of the data required to determine the "count" for payment of ACA fees and specifically a spreadsheet of data required for Section 6055 and 6056 reporting requirements. The Section 6055 and 6056 data required will, at a minimum, indicate the member's Social Security number, relationship to the subscriber, name, date of birth, address and the number of days covered in each month of the reporting period.

12. Initial distribution of the Plan's Summary Plan Description (SPD), ID card, Summary of Benefits and Coverage (SBC) and Uniform Glossary via mail to the home of all covered employees and retirees. The distribution cost should be included in the administrative fee. Separate costs for printing and/or distribution, must be included in the bid.

13. Administer comprehensive utilization review, large case management, disease management, coordination of benefits, subrogation, and hospital bill audits across medical, dental, and vision plans, where applicable.

14. Provision of a pre-natal and high-risk pregnancy program, disease management program, and health and wellness program. A description of these programs should be provided.

15. Administration of COBRA including receipt of premiums (initial notice to be provided by the City.)

16. Provision for all other duties, responsibilities, materials, and reports required for the professional administration of the Plan on a day-to-day basis.

17. Maintenance of the Plan in accordance with all federal and state requirements as well as legislative up-dates to client.

18. Check register or report of paid claims to coincide with requests for payment, where applicable.

19. Monthly report of basic benefit paid data for in-network and out-of-network providers by major category, i.e., inpatient hospital, outpatient hospital, inpatient physician

20. Medical/surgical, outpatient physician medical/surgical, primary care, specialty care, pharmacy, etc. Data will be maintained for two categories to include Active and Retired.

21. Please provide a sample of all standard reports available.

22. Provide an annual comprehensive report of experience and utilization with

analysis and provision. Assign a qualified representative to meet with the City for an annual review. The annual review should include a projection of cost with suggested funding rates for Active and Retired using the City's tiered rate structure.

23. Qualified representative to work with the City's Department of Human Resources in all aspects of the Plan and especially service and claim problems.

24. Actuarial assistance in pricing benefit modifications and projection of future cost. This will include an annual analysis with recommendations for maintaining compliance with all federal regulations and especially the Affordable Care Act.

25. Assistance with employee meetings during implementation, open enrollment and as needed.

26. Adequate staffing for membership services including complaint resolution.

27. Maintain professional liability and errors and omissions insurance during the term of this contract.

28. Allow for and cooperate with the audit of all records and documents related to this contract and payments made by the City under this contract, when requested.

29. Provide a hold harmless contract provision for failure to perform under the contract for both administrative duties and managed care services.

30. Agree to provide timely notice of any major changes in your ability to administer the program, provider contracts or listing of network providers.

31. Provide for the Affordable Care Act (ACA) required appeal procedure including the independent third-party appeal review.

This is not a comprehensive list of administrative services required by the City for administration of the Plan. It is a listing of major items which the City expects should be included at a minimum. Please provide the information requested and specify any item listed that is in conflict with your ability to perform. State the number of the item and provide a brief explanation of why the service is not available or an alternative service that can be provided. Please indicate the item number for those items requiring a written response. The City fully expects that the administrator will perform all duties and responsibilities required for the efficient and professional administration of the Plans on a day-to-day basis. Please feel free to describe any specific service that your organization performs that might be unique or valuable to the administration of the City 's self-funded Medical Plan and fully-insured Dental and Vision Plans.

Attachment E-2 Specific Inquiries Regarding Administrative Services

Proposers must fully complete and submit the **Technical & Administrative Questionnaire** located in **Appendix E** of this RFP. Responses must be returned with the proposer's final submission package. Failure to respond to all inquiries in Appendix D may result in disqualification.

(List each question with your response)

1. Identify and describe your organization 's relevant experience with administering benefits for plans of similar size and design, number of members and number of benefits paid.

2. Does your organization maintain a service office in Jackson, MS? If not, provide the location(s) from which your organization will pay this account's medical, dental and vision claims.

3. The bidder will provide a description of their resources for effective and timely customer service. This will include current customer service staffing levels, call reporting and tracking, performance management, and other related activities.

4. Provide a brief description of your organization 's electronic eligibility management including the timeframe for updating records when eligibility information is received.

5. Is your organization accredited by:

	Yes	No
URAC (Utilization Review Accreditation Commission)		
National Committee for Quality Assurance		
Joint Commission for Accreditation of Healthcare Organizations		

6. Is your disease management program internal or administered under contract? If by contract who is the provider?

7. Are your telephonic medical services (as it relates to Disease Management) internal or outsourced? If outsourced who is the provider?

8. Is your organization fully compliant with the CMS mandate requiring all HIPAA covered entities to have EDI Version 501O?

9. Please explain how the funding process for the orderly payment of emerging Plan benefits operates. When is the transfer of funds called and required? May payment be made by wire transfer or check? Is a certain financial institution required? Are there any additional charges involved with reconciling accounts and if so please state?

10. Is an advance deposit required on the account? If yes, please provide the amount and state when the deposit is applied.

11. Describe your organization's proposed implementation plan and timeline to meet the City's expected January 1, 2027 startup date. The plan and timeline should address all transition activities and state the extent that the City's staff will be required to assist. Please identify start-up fees associated with implementation, if any.

12. Identify the individual who will have ultimate responsibility for each stage of the implementation process. Will this individual be dedicated to the implementation of the City's account?

13. Complete the following table illustrating claims processing capacity based on your 2025 book of business excluding internal clients:

Item	TPA (Total Book of Business)
Number of claims processed in 2025	
% of claims paid within 30 days	
% of claims denied within 30 days	
Standard claims processing turnaround time from date received to date paid/rejected	_____ **Days**

14. Does your claim payment system provide a capability for generating normative data for comparison of the City's experience to other plans of similar size and demographics?

15. How do you notify a subscriber of a denied claim? Please provide an example of such notification.

16. What was your accuracy rate for claims administration in 2025 for the office(s) that will be administering claim payment for the City?

17. Specify the documentation procedures for inquiries to the customer service department. Are calls recorded?

18. How does your organization identify claims involving subrogation? Do you have the ability to suspend payment of claims until the individual submits a Right of Recovery or Subrogation Agreement? If you outsource subrogation and recovery, provide the name of that organization and costs. Does your subrogation include product liability?

19. Please provide information on how you determine the usual, customary, and reasonable (UCR) allowance for non-network services. How often is your UCR schedule updated (health, dental and vision)? Can you apply the negotiated PPO provider fees or discounted rate as the UCR for limiting benefits?

20. Provide a brief explanation of your organization's inpatient hospital certification process.

    Can you pre-certify outpatient hospital procedures? If yes, explain the process. Please include in the explanation the procedure for obtaining the pre-certification and how the provider and subscriber are notified of the approval or denial.

21. Can you provide an online link of your claim payment system to the City's Employee Benefits Section for input of additions and terminations, review of participant records, etc.? Can you provide the hardware and training to support this in-house communications system? Is there any additional cost for this system?

22. Describe your online access for employees to review claims data, submit claims, and obtain other information such as health assessment, SPD, SBC, etc.

23. How far back can you recover claims if an employee's termination date is reported late?

24. Upon contract termination, will your organization agree to pay run-out claims for eighteen (18) months or longer from the termination date at no additional cost? If no, provide the cost for this service.

25. Will your organization provide notice to the reinsurance carrier selected by the City for all claims that exceed the target benefit paid amount or target diagnosis providing all information required by the reinsurance carrier? If not, describe what actions will be taken by your organization to ensure that the City has the required information for initial and subsequent reinsurance claim filings.

26. If your organization has special relationships with reinsurance carriers which allow for advance funding of excess claims, lower administrative fees for reinsurance placement and other contractual advantages, please explain?

27. If you are selected in the final review, given you are provided with the required data, provide a sample of payment of the City's claims for the last 6 months to verify the potential savings through your system. This will be important as the preferred provider network allowed amounts will be the most significant factor in determining the cost effectiveness of any administrator. The model to be presented by major line of coverage: hospital inpatient, hospital outpatient, outpatient physician medical, physician surgical, prescription drugs.

ATTACHMENT E - 3 Provider Disruption

Proposers must also complete the following questionnaire and submit Contract Pricing Exhibit located in Attachment H and the Provider Disruption in Attachment I of this RFP. The City of Jackson will rely heavily on the negotiated hospital, physician, and prescription drug allowed amounts provided in Appendix E to evaluate the financial feasibility and cost-effectiveness of each proposal. Failure to complete these tables in their entirety may result in the disqualification of the proposal.

1. Geographic area covered by your preferred provider network (in and out of MS)?

2. Census data for the health plan including zip codes can be found in the City Data Package (section 5.1) of this RFP. Please use this data to provide a site match with your networks.

3. Number of network primary care physicians in MS?

4. Number of network specialty care physicians in MS?

5. Name of network hospital facilities in MS?

6. Number of participating pharmacies in MS?

7. Is the network provider directory available for participants to access on-line?

8. How do you communicate changes in your network providers to plan participants? Do you have a periodic newsletter sent to participants advising them of changes and informing them of how best to utilize their program?

9. Do you provide a full-time medical, dental, and vision director, if applicable? If yes, please state name, experience, and years with your organization. If no, please explain.

10. Do you provide a full-time pharmacy director? If yes, please state name, experience, and years with your organization. If no, please explain.

11. Are there any significant medical services, such as organ transplant, which are not covered within your network of providers? If yes, please list such services.

12. Do you have a PPO for chiropractors?

13. Do you have a specific network of providers for bariatric surgery?

14. Please provide information concerning your managed care network.

15. Do you have a process for obtaining discounts on out-of-network services? If this is done through another PPO network, please state the name of the network? On average, what is the discount received on out-of-network hospital facilities through this re-pricing?

ATTACHMENT E - 4. Provider Contracts

The financial arrangement your organization has negotiated with network providers is most important to this review. The City's Medical Benefit Plan already enjoys favorable financial arrangements with hospitals and other medical providers. This information will be submitted to the Review Committee which will make every effort to maintain confidentiality. The negotiated fee for medical services, prescription drugs and other services is the single most important financial factor in the review of proposals.

HOSPITAL INPATIENT & OUTPATIENT:

State the financial arrangements for all hospital facilities, including specialty care facilities, in Mississippi. Include the following for each facility:

1. List the hospital per diem amount and basis (prospective or retrospective) or other financial arrangements for each network facility. If retrospective, estimate the average annual percent adjustment at settlement. Indicate if global or Diagnostic Related Group (DRG) based. If DRG based list amount for each major grouping. Specific information must be provided for the hospitals listed in the Specific Provider Confirmation section of this RFP.

2. State any financial arrangements at a network facility that would limit the Plan's liability for any one confinement.

3. List the hospital outpatient, surgical center, or other facility discount for: surgery, emergency room, medical care and diagnostic services.

4. List per diem amount or other financial arrangement at specialty care facilities providing treatment of mental and substance abuse conditions.

5. List per diem amount or other financial arrangement with hospitals providing organ transplant services for each network facility.

6.List per diem amount or other financial arrangements with hospitals for services not provided by your participating facilities in Mississippi, i.e., burn center, premature infant intensive care, centers of excellence, etc.

7.List any other financial arrangements you may have concerning hospitals, specialty care, hospice, rehabilitation, dialysis or other inpatient and outpatient facility services.

OTHER PROVIDERS:

1. Do you have provider contracts for home health care, renal dialysis, durable medical equipment, hospice care? If yes, please give an estimate of the contractual savings off billed charges for MS.

2. Do you have special programs or provider contracts to deal with the high cost of ESRD renal dialysis including monitoring the period of usage for Medicare take-over?

3. Provide a description of your pharmacy program including information on pricing, formulary, rebate and discount arrangements and mail order options.

4. Do you have contractual arrangements with laboratories in Mississippi? If yes, please name the providers and state the approximate discount off billed charge savings.

5. If you use a third-party PPO network or networks, please provide the name or names of the networks including those used to re-price out-of-network claims.

Complete the following tables indicating whether the specific provider is within your organization's network.

ATTACHMENT E – 5. Specific Provider Confirmation - Physicians

Physician	Provider Type	NPI #	Network Provider? Yes or No
Young, Tammy	Specialist	1013911668	
Qu, Guangzhi	Specialist	1790780716	
Sheehan, Natale	Specialist	1518178524	
Cleveland, Nicole	Specialist	1639380207	
Williamson, Thomas	Primary Care	1023429941	
Propes, Bryan	Specialist	1174594675	
Venarske, Daniel	Specialist	1003892357	
Fowler, Amanda	Specialist	1215224886	
Patel, Manubhai	Specialist	1487659850	
Baker, Justin	Primary Care	1639119589	
Lennep, Day	Specialist	1538509955	
Ramsey, James	Specialist	1376531582	

Lowry, Mary Allyson	Specialist	1285922465	
Hines, Brittany	Specialist	1508201815	
Borne, Michael	Specialist	1588750178	
Wadsworth, Margaret	Specialist	1821291790	
Moore, Robert	Primary Care	1841281276	
Orr, Wayne	Specialist	1013132406	
Adkins, Todd	Specialist	1629056502	
Ellison, Parker	Specialist	1942311212	
Lawin, Penny	Specialist	1346238540	
Johnson, Temeka	Specialist	1306947577	
Wilson, Mark	Specialist	1184612368	
Gibson-Mckee, Lisa	Specialist	1902940026	
Milner, Paul	Specialist	1356339782	

ATTACHMENT E - 6 Specific Provider Confirmation - Hospitals

Note: If these hospitals are Network Providers, you must submit specific negotiated fee information for these hospitals.

Hospital	Locatio	Network Provider	Per Diem 2026	Allowed Amount
MS Baptist Medical Center	Jackson		$	$
St Dominic Memorial	Jackson			
State of MS University	Jackson			
Merit Health South	Jackson			
Merit Health River Oaks	Flowood			
Merit Health Central	Jackson			
Merit Health Rankin	Brandon			
Brentwood Behavioral Healthcare	Flowood			
Psycamore Mental Health Therapy	Flowood			
Merit Health Womans Hospital	Flowood			

ATTACHMENT E-7 Pharmacy Benefit Manager (PBM) Transparency & Pricing Exhibit

City of Jackson, Mississippi

Applies to: Medical & Prescription Drug (Pharmacy) Proposers Only

Instructions for Proposers

This must be completed in full by (a) any Proposer offering an integrated Pharmacy Benefit Manager (PBM) arrangement as part of a self-funded medical/TPA proposal, and (b) any Proposer offering a stand-alone or carved-out PBM arrangement, regardless of whether the PBM is owned internally or subcontracted to a third party.

Every question requires a narrative response and, where a table is provided, a fully completed entry. "To Be Determined," "Standard Terms Apply," or blank responses will be treated as non-responsive for that item. If a question does not apply to the Proposer's model, state "N/A" and provide a brief written justification.

All pricing guarantees must be quoted on both an Average Wholesale Price (AWP) basis and an independent National Average Drug Acquisition Cost (NADAC) basis, so that the City can evaluate proposals against a benchmark that is not self-reported by the Proposer's own pricing file.

The City reserves the right to request supporting claims-level data, current book-of-business audited results, or third-party benchmarking reports (e.g., from an independent pharmacy consultant or auditor) to substantiate any guarantee quoted in this exhibit.

Section 1 — PBM Identification, Ownership & Compensation Model

1. Identify the exact legal entity name of the PBM that will administer the City's pharmacy benefit.

Response:

_____

_____

2. Is the PBM owned and operated internally by the Proposer, or subcontracted to a separate PBM? If subcontracted, identify the subcontracted PBM and describe the contractual relationship.

Response:

_____

_____

3. Disclose whether the proposed PBM is owned by, affiliated with, or under common corporate ownership with any of the following being proposed to the City: the medical TPA, the pharmacy network, the specialty pharmacy, the mail-order pharmacy, or the rebate aggregator. Describe the relationship in full, including parent-company structure.

Response:

_____

4. Confirm the PBM's compensation model for this proposal: Traditional (spread) pricing, Pass-Through pricing, or a Hybrid model. Describe exactly how the PBM is compensated under the proposed model, including any per-claim administrative fee, retained spread, or other revenue source.

Response:

_____

5. If Pass-Through pricing is proposed, certify whether the ingredient cost billed to the City on each claim will equal, dollar-for-dollar, the ingredient cost paid to the dispensing pharmacy, with no undisclosed markup, spread, or fee embedded in the ingredient cost. If any markup exists, disclose the amount and methodology.

Response:

_____

6. Identify the rebate aggregator, Group Purchasing Organization (GPO), or manufacturer-contracting entity used to negotiate rebates on the City's behalf, if any such intermediary exists. Disclose whether that entity is affiliated with the PBM and whether it retains any portion of manufacturer rebates before amounts are reported to the City.

Response:

_____

Section 2 — AWP and NADAC Pricing Guarantees

Complete the table below for each dispensing channel and drug type. AWP Discount Guarantee and NADAC Benchmark Guarantee must both be provided; do not leave either column blank. All guarantees must be stated as minimum discounts (e.g., "AWP - 18.00%") and will be held to an aggregate minimum performance standard, reconciled per the frequency stated in Section 3.

Channel	Drug Type	AWP Discount Guarantee (%)	NADAC Benchmark Guarantee (%)	Dispensing Fee ($)	Guarantee Basis
Retail (up to 30-day supply)	Generic				
Retail (up to 30-day supply)	Brand				
Retail 90 / Maintenance	Generic				
Retail 90 / Maintenance	Brand				
Mail Order / Home Delivery	Generic				
Mail Order / Home Delivery	Brand				
Specialty (Retail)	All				
Specialty (Mail / Home Delivery)	All				

7. Estimate, in aggregate, the percentage difference between billed charge (retail cash price) and the allowed amount for prescription drugs, before application of copay or coinsurance.

Response:

_____

8. State whether the AWP and NADAC guarantee above will be honored on an aggregate portfolio basis, a per-claim basis, or both. Describe the reconciliation methodology if aggregate.

Response:

_____

Section 3 — Generic Effective Rate (GER) and Brand Effective Rate (BER) Guarantees

GER and BER guarantees must be quoted, reconciled, and trued-up as described below. A guarantee that is not independently reconciled and financially enforced will not be considered a binding guarantee for evaluation purposes.

Metric	Guaranteed Rate	Reconciliation Frequency	True-Up Methodology	Financial Penalty for Shortfall
Generic Effective Rate (GER) — % off AWP				
Brand Effective Rate (BER) — % off AWP				
Overall Blended Effective Rate				

9. Confirm whether GER/BER guarantees are reconciled against the Proposer's full book of business, the City's claims only, or a custom peer group. If a peer group is used, describe its composition.

Response:

_____

10. Describe what happens if a guarantee is missed mid-contract — is the shortfall paid to the City in cash, credited against future invoices, or handled another way? State the timeframe for payment of any shortfall.

Response:

_____

Section 4 — Direct and Indirect Remuneration (DIR) Fees

11. Does the PBM assess Direct and Indirect Remuneration (DIR) fees, or any other retroactive fee, against network pharmacies after the point of sale?

Response:

_____

12. If DIR fees are assessed, describe the fee type(s), the basis for assessment (e.g., pharmacy performance metrics), and the typical timing of assessment relative to the original claim.

Response:

_____

DIR / Retroactive Fee Type	Assessed Against Pharmacy? (Y/N)	Passed to City / Plan? (Y/N)	Est. Annual Impact ($ or PMPM)	Disclosure Timing
Performance-Based DIR				
Network Fee / Access Fee				
Other (specify)				

13. Certify whether DIR fees or other retroactive pharmacy fees will, directly or indirectly, increase the City's net cost beyond the guarantees quoted in Section 2 and Section 3 of this exhibit. If yes, explain how the City can verify the true net cost.

Response:

_____

Section 5 — Manufacturer Rebate Terms and Guarantees

14. Are 100% of manufacturer rebates attributable to the City's claims passed through to the City? If not, state the exact percentage retained by the PBM or any intermediary, and the basis for retention.

Response:

_____

15. Are rebates aggregated directly by the PBM, or by an outside rebate aggregator or GPO? If by another entity, is there a rebate administration fee or withhold charged for that service, and how much?

Response:

_____

Rebate Category	Guaranteed $ (PMPM or per Rx)	% Passed Through to City	Payment Frequency	True-Up Timing
Brand Formulary Rebates				
Specialty Drug Rebates				

Rebate Category	Guaranteed $ (PMPM or per Rx)	% Passed Through to City	Payment Frequency	True-Up Timing
Generic Rebates (if applicable)				

16. Are rebate amounts guaranteed on a per-brand-claim basis, an aggregate portfolio basis, or both? If aggregate, describe how shortfalls or surpluses are handled at reconciliation.

Response:

_____

17. Disclose whether formulary placement decisions are influenced, in whole or in part, by manufacturer rebate contracts. Identify, at a high level, which drug classes on the proposed formulary are rebate-driven versus placed solely on clinical/cost-effectiveness grounds.

Response:

_____

Section 6 — Maximum Allowable Cost (MAC) List Transparency

18. Will the City, or an independent third-party auditor retained by the City, have the right to review the PBM's MAC list(s) applicable to the City's plan, including pricing methodology and update frequency?

Response:

_____

19. How frequently are MAC list prices updated, and what data sources are used to set MAC pricing?

Response:

_____

20. Does the PBM apply the same MAC list and reimbursement methodology to its own affiliated or owned pharmacies as it does to unaffiliated network pharmacies? Disclose any differential treatment.

Response:

_____

21. Describe the pharmacy appeals process when a network pharmacy is reimbursed below its acquisition cost under the MAC list.

Response:

Section 7 — PBM-Specific Audit Rights

22. Confirm that the City, or an independent third-party auditor selected by the City, will have the unrestricted right to conduct a full claims-level audit of the PBM specifically (not only the medical TPA), including ingredient cost, dispensing fees, rebates received and passed through, and DIR fee activity.

Response:

---

23. State any contractual limitations the PBM ordinarily imposes on audit scope, audit frequency, sample size, or auditor qualifications, and confirm whether the Proposer will waive such limitations for the City's contract.

Response:

---

24. State the record retention period the PBM will commit to for audit purposes following contract termination (minimum 3 years requested).

Response:

Section 8 — Specialty Pharmacy and Site-of-Care Management

25. Is the specialty pharmacy proposed to the City owned by, or affiliated with, the PBM? If the City may choose an independent specialty pharmacy, describe that option and any pricing difference.

Response:

---

26. Describe the PBM's limited-distribution-drug sourcing process, and whether the City's members are required to use the PBM's own specialty pharmacy for limited-distribution drugs.

Response:

---

27. Describe any white-bagging, brown-bagging, or site-of-care steering programs proposed, including which drugs are affected and the projected cost impact to the City.

Response:

---

28. Describe how specialty drugs billed under the medical benefit (buy-and-bill, physician-administered) are priced, managed, and reported, and how that coordinates with the pharmacy benefit reporting in this exhibit.

Response:

_____

Section 9 — 340B Claims and Copay Assistance Programs

29. Describe the process used to identify 340B-eligible claims and disclose whether any savings associated with 340B pricing are retained by the PBM, the dispensing entity, or passed through to the City.

Response:

_____

30. Does the Proposer administer a copay accumulator or copay maximizer program? If so, describe how manufacturer copay assistance is applied, whether it counts toward the member's deductible/out-of-pocket maximum, and any savings retained by the PBM.

Response:

_____

Section 10 — Formulary Governance and Conflict-of-Interest Disclosure

31. Describe the composition and independence of the Pharmacy & Therapeutics (P&T) committee responsible for formulary decisions, including whether committee members have any financial relationship with manufacturers.

Response:

_____

32. Certify that no financial bonuses, commissions, volume rebates, or other incentives are paid to PBM staff based on formulary placement decisions, drug switching, or member-level prescribing interventions, consistent with the RFP's general prohibition on volume-based incentives.

Response:

_____

Certification

The undersigned certifies that the information provided in this exhibit is complete, accurate, and may be relied upon by the City of Jackson in evaluating this proposal. The undersigned further acknowledges that any pricing guarantee, rebate guarantee, or

transparency commitment made in this exhibit is intended to be binding and enforceable in the resulting contract, subject to the reconciliation and true-up terms stated above.

Proposer / PBM Legal Name:	Date:
Authorized Signature:	Title:

ATTACHMENT E – 8 High-Cost Claimant Questionnaire

High-Cost Claimant Support: Detail specific administrative strategies used to identify, monitor, and mitigate catastrophic or high-cost medical claims to protect the City's self-funded financial exposure. Proposers must complete Attachment E-8 (Questionnaire on High-Cost Claimant Support) in its entirety.

1. What clinical protocols (severity of illness and intensity of treatment) are used to determine medical necessity for medical services? Who determines medical necessity? Who performs pre-certification of a hospital admission? Who performs continued stay review?

2. Does Utilization Review provide for surgical review in addition to medical necessity for hospitalization? Describe the process.

3. Does Utilization Review provide for review of outpatient surgery and outpatient hospital procedures and visits? Please describe the process.

4. Does Utilization Review include home health care, hospice care, extended care, and high-cost diagnostic procedures? If yes, briefly describe how UR is triggered and the level of UR performed for the service.

5. How does your system determine need for case management?

6. Please feel free to submit any additional information concerning your utilization review program that might assist the Review Committee.

ATTACHMENT F: Dental Plan

The dental plan is separate from the health plan and paid for 100% by the employee.

The City of Jackson offers a voluntary, fully insured dental plan that is 100% employee-paid via payroll deduction. The City provides no direct financial contribution toward the premium, nor does the City assume any liability for benefit costs or claims. The City's role is strictly limited to sponsoring the group plan and processing premium payments via payroll deduction.

Dental Proposal Questionnaire

Proposers must provide a complete, narrative response to each item below. If a specific question does not apply to your proposed funding mechanism or plan design, explicitly state "N/A" and provide a brief justification.

1. **Legal Entities:** Identify the exact legal entity underwriting dental coverage and administering claims.

2. **Delivery and Funding Models**: Confirm the exact plan design and funding mechanism proposed:

Funding: fully insured versus self-funded.

Design: PPO, Passive PPO, Indemnity, alternative Managed Care, or another arrangement.

Benefit Grid & Plan Design: Provide a benefit grid for each dental option proposed. Your response must explicitly define:

a) Coinsurance levels for preventive, basic, major, orthodontia;
b) Individual and Family deductibles (and what services they apply to),
c) Calendar Year or annual maximum, lifetime, and Orthodontia lifetime maximum,
d) Waiting periods, missing-tooth exclusion rules, and frequency limitations (e.g. cleanings, x-rays)
e) Out-of-network reimbursement (e.g. 90th Percentile of Usual, Customary, and Reasonable (UCR) vs. Maximum Allowable Charge (MAC)

4. **Plan Deviation:** Identify and explain every benefit deviation or limitation from the City's current dental plan. If there are zero deviations, provide an affirmative statement confirming an exact match.

5. **Dental Network Breadth:** Describe the dental provider network, network tiers, provider counts, in network general practitioners and specialist providers within the local Mississippi service area, credentialing standards, and provider search tools.

6. **Provider Disruption Analysis:** Provide dental provider disruption results, execute and attach a dental provider disruption analysis if the City provides utilization/provider data. State the exact percentage match rates for both general dentists and key dental specialists in the Hinds County area.

7. **Takeover and Transition Protections:** Describe takeover provisions, treatment-in-progress, orthodontia-in-progress, predetermination, claims processing, appeals, and member service.

8. **Premium Rates & Fee Structuring:** Provide rates by tier, rate guarantees, minimum participation requirements, and renewal methodology.

9. **Renewal Underwriting Methodology:** Identify all commissions, fees, bonuses, overrides, or other compensation.

10. **Total Compensation Transparency:** Disclose and itemize all commissions, broker fees, enrollment bonuses, volume overrides, or any alternative third-party compensation built into your proposed

11. **Claims & Member Service Delivery:** Describe your dental claims processing standards, average turnaround times, formal member appeals/grievance processes, dedicated customer service phone infrastructure, and digital member tools.

12. **Transition & Open Enrollment:** Describe open enrollment support, member communications, ID card process, and implementation timeline.

ATTACHMENT G: Vision Plan

The City of Jackson does not currently offer a vision benefit. This will be a new, voluntary, fully insured vision plan, 100% employee-paid via payroll deduction. The City provides no direct financial contribution toward the premium, nor does the City assume any liability for benefit costs or claims. The City's role is strictly limited to sponsoring the group plan and processing premium payments via payroll deduction.

Vision Proposal Questionnaire

Proposers must provide a complete, narrative response to each item below. If a specific question does not apply to your proposed plan design, explicitly state "N/A" and provide a brief justification.

1. **Legal Entities:** Identify the exact legal entity underwriting vision coverage and administering claims.
2. **Plan Design and Underwriting:** Confirm the plan design proposed — PPO, Passive PPO, indemnity, or alternative managed vision arrangement — and confirm the plan is fully insured, consistent with Section 3.1 of this RFP.
3. **Benefit Grid & Plan Design:** Provide a benefit grid for each vision option proposed. Your response must explicitly define:
    - Copays for exam and materials (separately)
    - Frequency limits for exam, lenses, and frames (e.g., 12/12/12 or 12/12/24 months)
    - Lens options covered (single vision, bifocal, trifocal, progressive/lined multifocal) and any allowances or copays for lens enhancements (anti-reflective, polycarbonate, transitions, tint)
    - Frame allowance amount and any retail/network-specific variation
    - Contact lens allowance, and whether elective and medically necessary contacts are covered separately
    - Out-of-network reimbursement schedule
4. **Baseline Plan Summary:** Since vision has not previously been offered, describe your organization's standard/base plan design being proposed as the City's baseline offering, and identify any buy-up or alternative tier options available.
5. **Vision Network Breadth:** Describe the vision provider network, including private-practice optometrists, ophthalmologists, and retail/chain locations (e.g., Walmart Vision Center, LensCrafters), provider counts within the Jackson/Hinds County service area, credentialing standards, and provider search tools.

6. **Network Adequacy Analysis:** Because this is a new benefit with no current enrollees to disrupt, provide a network adequacy analysis instead of a disruption analysis — i.e., provider density and average member travel distance to the nearest in-network provider within the Hinds County service area.
7. **Implementation and Transition:** Describe your standard implementation timeline, member communications, and open enrollment support for a first-time vision offering, including any enrollment materials designed specifically for a plan with no prior member familiarity.
8. **Premium Rates & Fee Structuring:** Provide rates by tier, rate guarantees, minimum participation requirements, and renewal methodology.
9. **Renewal Underwriting Methodology:** Identify all commissions, fees, bonuses, overrides, or other compensation factored into renewal pricing.
10. **Total Compensation Transparency:** Disclose and itemize all commissions, broker fees, enrollment bonuses, volume overrides, or any alternative third-party compensation built into your proposed rates.
11. **Claims & Member Service Delivery:** Describe your vision claims processing standards, average turnaround times, formal member appeals/grievance processes, dedicated customer service phone infrastructure, and digital member tools.
12. **Materials Ordering & Fulfillment:** Describe how members order glasses/contacts (in-network lab, direct ship, online ordering), average fulfillment turnaround, and any online/retail purchase options (e.g., online frame and contact ordering platforms) included at no extra cost.
13. **Preferred Provider Network in MS:** Do you have a vision preferred provider network in Mississippi? Estimate the percent savings off billed charges provided by that network.
14. **UCR Update Frequency:** How often do you update your vision UCR values?
15. **Medical/Vision Integration:** Describe your capability to integrate and share clinical information between vision and medical for diabetic eye exam tracking and other disease-management coordination.

Provide your UCR value at the 90th percentile and the PPO allowed amount for the vision services listed below.

Procedure Code	Vision Service	UCR Allowance	PPO Allowance
92004	Comprehensive eye exam, new patient		
92014	Comprehensive eye exam, established patient		
92015	Refraction		
V2020	Frames		
V2100	Single vision lens, sphere		
V2200	Bifocal lens, sphere		
V2300	Trifocal lens, sphere		
V2781	Progressive/lined multifocal lens		
V2760	Anti-reflective coating		
V2784	Polycarbonate lens		
V2744	Photochromatic/tint lens		
V2500	Contact lens, spherical (elective)		
V2510	Contact lens, gas permeable, toric/prism		
V2520	Contact lens, hydrophilic, spherical		
92310	Contact lens fitting		
V2627	Scleral contact lens (medically necessary)		

Please provide a sample report of utilization and cost for your vision program and any other information explaining the advantages of the program.

ATTACHMENT H - Detailed Pricing Forms

H-1 Medical Pricing for Self-Funded Plans

Plan Option	Tier	Current Enrollment	Monthly Premium	Annual Premium	Rate Guarantee	Commission Included?	Notes
	Employee Only	845	$[ ]	$[ ]		[Y/N/$]	
	Employee + 1	251	$[ ]	$[ ]		[Y/N/$]	
	Employee + Family	154	$[ ]	$[ ]		[Y/N/$]	

H-2 Dental Pricing for Fully-Insured Plans

Plan Option	Tier	Current Enrollment	Monthly Premium	Annual Premium	Rate Guarantee	Commission Included?	Notes
	Employee Only	781	$	$		[Y/N/$]	
	Employee + 1	225	$	$		[Y/N/$]	
	Employee + Family	195	$	$		[Y/N/$]	

H-3 Vison Pricing for Fully-Insured Plans

Plan Option	Tier	Current Enrollment	Monthly Premium	Annual Premium	Rate Guarantee	Commission Included?	Notes
	Employee Only	Not Available	$	$		[Y/N/$]	
	Employee + 1	Not Available	$	$		[Y/N/$]	
	Employee + Family	Not Available	$	$		[Y/N/$]	

H-4 Optional ASO / Stop-Loss Pricing

Cost Component	Amount / Rate	Basis	Included?	Notes
ASO Administration	$	PEPM	[Y/N]	
Network Access	$	PEPM or %	[Y/N]	
PBM / Rx Admin	$	PEPM / claim	[Y/N]	
Care Management	$	PEPM	[Y/N]	
Specific Stop-Loss Premium	$	PEPM	[Y/N]	Specific deductible: $[ ]
Aggregate Stop-Loss Premium	$	PEPM	[Y/N]	Attachment point: [ ]%
Expected Claims	$	Annual	[Y/N]	

Cost Component	Amount / Rate	Basis	Included?	Notes
Maximum Claims / Liability	$	Annual	[Y/N]	
Run-Out / Terminal Liability	$	Annual or PEPM	[Y/N]	
Implementation Fees	$	One-time	[Y/N]	

ATTACHMENT I - Network Disruption and Provider Access Form

Measure	Medical Response	Dental Response	Notes
Overall provider match rate based on City file	%	[ ]%	
Primary care match rate	%	N/A	
Specialist match rate	%	N/A	
Hospital/facility match rate	%	N/A	
Behavioral health match rate	%	N/A	
Pharmacy match rate	%	N/A	
Dental provider match rate	%	[ ]%	
Vision provider match rate	N/A	[ ]%	
Top disrupted providers by claim volume	[Attach]	[Attach]	

Measure	Medical Response	Dental Response	Notes
Transition-of-care process	[Describe]	[Describe]	

ATTACHMENT J - Implementation Plan

Milestone	Responsible Party	Target Date	Dependencies / Notes
Contract/policy finalization	City / Proposer		
BAA / data agreements executed	City / Proposer		
Eligibility file layout approved	City / Proposer		
Initial eligibility file sent	City		
Eligibility loaded and audited	Proposer		
Open enrollment materials approved	City / Proposer		
Employee meetings/webinars	Proposer / City		
ID cards issued	Proposer		
Provider/Rx transition communications	Proposer		

Milestone	Responsible Party	Target Date	Dependencies / Notes
Coverage live	Proposer		
Post-implementation audit	City / Proposer		

ATTACHMENT K: Confidentiality and Non-Disclosure Agreement

Employee Benefits Request for Proposals

This Confidentiality and Non-Disclosure Agreement ("Agreement") is entered into as of the date of execution by and between **The City of Jackson (“City”)** and **_____ (“Recipient”)**.

1. Purpose

The City is conducting a competitive procurement for employee benefits and related insurance services ("RFP"). In connection with the procurement, the City may provide Recipient with certain non-public information, including historical claims experience, enrollment information, benefit plan information, and other data necessary for Recipient to prepare and submit a proposal.

Recipient agrees to receive and use such information solely in accordance with the terms of this Agreement.

2. Confidential Information

For purposes of this Agreement, "Confidential Information" includes, without limitation:

- Historical medical, pharmacy, dental, vision, life, disability, and other employee benefit claims data;
- Enrollment and census information;
- Employee demographic information;
- Benefit plan design information;
- Financial information relating to employee benefit programs;
- Experience reports, utilization reports, actuarial information, and underwriting information;
- Any documents, spreadsheets, electronic files, reports, or other materials designated as confidential or which reasonably should be understood to be confidential.

Confidential Information includes information provided in electronic, written, oral, or any other form.

3. Permitted Use

Recipient shall use the Confidential Information solely for the purpose of evaluating the procurement opportunity and preparing a response to the City's Request for Proposals.

Recipient shall not use the information for marketing, solicitation, benchmarking, commercial purposes, or any purpose unrelated to the RFP.

4. Non-Disclosure

Recipient shall not disclose Confidential Information to any person except:

- employees of Recipient having a legitimate need to know;
- retained actuaries, consultants, attorneys, or subcontractors directly involved in preparing the proposal;

Provided such individuals are subject to confidentiality obligations at least as restrictive as those contained herein. Recipient shall remain responsible for any breach by its employees, consultants, agents, or subcontractors.

5. Protection of Information

Recipient agrees to exercise reasonable administrative, technical, and physical safeguards to protect Confidential Information against unauthorized access, disclosure, alteration, or destruction.

Recipient shall maintain the Confidential Information with at least the same degree of care it uses to protect its own confidential information, but in no event less than a commercially reasonable standard of care.

6. Privacy and Protected Information

Recipient acknowledges that the information provided may include sensitive employment, financial, or health-related information.

Recipient agrees to comply with all applicable federal and state privacy laws governing the protection of such information.

Recipient further acknowledges that the City intends to provide de-identified and/or aggregated claims information whenever practicable. Recipient shall not attempt to identify, contact, or otherwise determine the identity of any individual represented in the data.

7. Unauthorized Disclosure

Recipient shall notify the City in writing immediately, and no later than twenty-four (24) hours after becoming aware of:

- any unauthorized access to Confidential Information;
- any unauthorized disclosure;
- any loss or compromise of Confidential Information.

Recipient shall cooperate fully with the City in mitigating any such incident.

8. Return or Destruction

Within thirty (30) days following:

- completion of the procurement;
- cancellation of the RFP
- withdrawal of Recipient's proposal; or
- written request by the City,

Recipient shall either:

(a) return all Confidential Information to the City; or

(b) permanently destroy all Confidential Information, including electronic copies, extracts, summaries, analyses, notes, and backup copies to the extent reasonably practicable.

Upon request, Recipient shall provide written certification that such destruction has been completed.

9. Ownership

All Confidential Information remains the exclusive property of the City.

Nothing contained in this Agreement grants recipient any ownership interest, license, or intellectual property rights in the Confidential Information.

10. Public Records

Recipient acknowledges that the City is subject to applicable public records laws.

Nothing in this Agreement shall require the City to withhold records if disclosure is required by law, court order, or other legal process.

11. No Warranty

The Confidential Information is provided solely for convenience in preparing a proposal.

The City makes no representation or warranty regarding the completeness or accuracy of the information and assumes no liability for Recipient's reliance upon it.

Each proposer is responsible for conducting its own due diligence.

12. Remedies

Recipient acknowledges that unauthorized disclosure of Confidential Information may cause irreparable harm to the City for which monetary damages may be inadequate.

Accordingly, the City shall be entitled to seek injunctive relief, specific performance, and any other remedies available at law or in equity.

13. Term

This Agreement shall become effective upon execution and shall remain in effect for five (5) years following completion or cancellation of the procurement, except that obligations relating to information protected by applicable law shall survive for so long as required by law.

14. Governing Law

This Agreement shall be governed by and construed in accordance with the laws of the State of Mississippi.

Venue for any action arising under this Agreement shall lie in the appropriate state court located within the State of Mississippi.

15. Entire Agreement

This Agreement constitutes the entire agreement between the parties concerning the Confidential Information disclosed in connection with this procurement and supersedes all prior discussions or understandings relating thereto.

CITY OF _____

By: _____

Name: _____

Title: _____

Date: _____

RECIPIENT

Company: _____

By: _____

Name: _____

Title: _____

Date: _____

15. Appendices / Reference Documents

This section contains critical reference documents specific to the City of Jackson’s current medical and dental benefit plans. Proposers must thoroughly review these materials to align their proposed network provider fee structures, administrative costs, and discount arrangements with the City's current favorable benchmarks.

APPENDIX 1 - Current Summary Plan Description (SPD) / Benefit Summary

Click the link below to access the SPD.

APPENDIX 2 – Current Benefit Design Grids (Medical and Dental)

CITY OF JACKSON - MS | Current Medical Plan Design

	PLATINUM PLAN	GOLD PLAN	SILVER PLAN	BRONZE PLAN
Plan Name	Choice +	Choice +	Choice +	Choice +
	Network	**Network**	**Network**	**Network**
Office Copay (PCP/SPC)	Primary Care Provider $20 Specialist $30	Primary Care Provider $20 Specialist $30	Primary Care Provider $20 Specialist $30	Primary Care Provider $20 Specialist $30
Other (IP/UC/ER)	Inpatient, Urgent Care, Emergency room subject to deductible & coinsurance	Inpatient, Urgent Care, Emergency room subject to deductible & coinsurance	Inpatient, Urgent Care, Emergency room subject to deductible & coinsurance	Inpatient, Urgent Care, Emergency room subject to deductible & coinsurance
Deductible (Indiv/Fam)	$400/$1,200	$1,000/$2,000	$2,500/$5,000	$5,000/$10,000
Coinsurance	75%	75%	75%	75%
Out-of-Pocket (Indiv/Fam)	$5,000 per covered person	$5,000/$10,000	$5,000/$10,000	$9,100/$18,200
Pharmacy Plan	$50 Deductible $10/$25/$50 copays	$50 Deductible $10/$25/$50 copays	$50 Deductible $10/$25/$50 copays	$50 Deductible $10/$25/$50 copays
	Out of Network	**Out of Network**	**Out of Network**	**Out of Network**
Deductible (Indiv/Fam)	$400/$1,200	$10,000/$20,000	$10,000/$20,000	$10,000/$20,000
Coinsurance	65%	65%	65%	50%
Out-of-Pocket (Indiv/Fam)	$5,000 per covered person	$15,800/$31,600	$15,800/$31,600	$15,800/$31,600

NOTE:

* The City of Jackson will pay the entire cost for $10,000 Basic Life and Accidental Death and Dismemberment (AD&D) for employees enrolled in the City's medical insurance.

** The City of Jackson may change the current medical plan to reflect two plan choices instead of four for for the 2027 Plan Year.

CITY OF JACKSON-MS | Current Dental Plan Design

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	$50 per person / $150 per family each calendar year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics, if applicable?	Yes			
Maximums	**Silver:** $1,000 per person each calendar year **Platinum:** $1,500 per person each calendar year			
D & P counts toward maximum?	**Silver:** Yes **Platinum:** No			
Waiting Period(s) **Silver**	Basic Services None	Major Services 6 Months	Prosthodontics 6 Months	Orthodontics N/A
Platinum	Basic Services None	Major Services 12 Months	Prosthodontics 12 Months	Orthodontics 12 Months

	Silver		Platinum	
Benefits and Covered Services*	**Delta Dental PPO dentists†**	**Non-Delta Dental PPO dentists†**	**Delta Dental PPO dentists†**	**Non-Delta Dental PPO dentists†**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %	100 %	100 %
Basic Services Fillings	80 %	80 %	80 %	80 %
Endodontics (root canals)	25 %	25 %	80 %	80 %
Periodontics (gum treatment)	25 %	25 %	80 %	80 %
Oral Surgery	25 %	25 %	80 %	80 %
Simple Extractions	50 %	50 %	80 %	80 %
Major Services Crowns, onlays and cast restorations	25 %	25 %	80 %	80 %
Prosthodontics Bridges, dentures and implants	25 %	25 %	80 %	80 %
Orthodontic Benefits Dependent children	0 %	0 %	50 %	50 %
Orthodontic Maximums	N/A	N/A	$1,000 Lifetime	$1,000 Lifetime