**Proposal for Health Benefit Consulting Services**

# Mansfield City School District

# 856 West Cook Road, Mansfield, Ohio 44907

## RFP Response Submission

GRADYBENEFITS

Grady Enterprises, Inc.
515 East Mound Street, Columbus, Ohio 43215

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Contact: Joe Grady, President

**RFP Submittal Deadline**

Close of business on Friday, June 20, 2025

Attention:

**Tammy Hamilla, District Treasurer**

**(419) 525-6400 ext 1005**

Grady Benefits is pleased to provide our response to the Request for Proposals (RFP) for Health Benefit Consulting Services as issued by the Mansfield City School District (MCSD or District). We appreciate the clear and concise nature of the RFP as presented and we have responded in the requested format to expedite your review of our response.

**This Response is submitted and certified under signature by:**

Applicant: Kevin Joseph Grady (President)
License: License #4191 and NPN #2766169

**Please address any questions to the attention of:**

Contact: Joe Grady, President
Phone: 614-224-4432
Mobile: 614-581-7242
Fax: 614-224-9212
Email: joe@gradyenterprises.com

## Acknowledgement of RFP Specified Sections:

Please accept our response as agreement to terms and conditions described within the District RFP as Issued. The following specified sections of the RFP were understood to be District expectations and are included under Appendix A within our response for reference and binding purposes only.

- **Introduction**
- **Confidentiality**
- **Benefits Overview**
- **Services**
- **Proposal Instructions**
- **General Information**

We are submitting our response to the Section **Presentation Expectations** below. We know it is difficult to relay our services through a written response, and we look forward to addressing your question in more detail during a group presentation. Please let us know if you have any immediate questions regarding our submission.

**RFP Response to Section PRESENTATION EXPECTATIONS | Each brokerage firm should be prepared to address the following during their presentation.**

## 1. Brief overview of your firm.

Grady Enterprises, Inc.
DBA, Grady Benefits
515 East Mound Street
Columbus, Ohio 43215

Our company is a family-owned and operated agency, where we firmly value our customers and the direct relationship we have with them. Grady Enterprises is dedicated to Core Employee Benefits. We do not dilute our services into Investments, Auto, Home, or other lines of coverage. We focus our expertise on group coverage for Ohio Public Entities.

We specialize in Public Education, specifically Public Schools and related educational organizations. This has been the agency's focus since 1989. **We currently provide benefit packages to over 350 Educational and Governmental entities**, including: public schools, educational service centers, career and technical centers, county boards of developmental disabilities, libraries, and universities.

Due to the specialization of our agency, we utilize a network of strategic partnerships and rely on information systems with cost-efficient services that are a pass-through to our customers.

We believe we possess unique advantages through our experience with educational platforms, product knowledge and collaborative networking of technological and professional services.

**History & Legal Organization:**

- Agency was originally co-founded as Group Benefits Agency in 1978 by Kevin Grady (Principal Retired).
- Group Benefits Agency provided direct client consulting and broker-wholesaler services until 1996 when Kevin Grady and Joe Grady separated the two-corporate divisions. The Broker-Wholesaler Division was sold, and Grady Enterprises was formed to maintain the direct client consulting services business and retained the educational and public sector book of business.
- Grady Enterprises, Inc. was then founded in 1996 exclusively providing consulting & brokerage of employee benefits.
- Sub-chapter S in 2003; C-Corporation prior
- Federal ID# 31-1461229

## 2. Structure, roles and expertise of the team that would service SCSD's account.

As a key account, the District would work directly with the executive level staff of our agency so we may provide the personal and high level of service requested and expected.

**Joe Grady, President (Industry since 1995)**
Primary contact for Administration and Department Heads, including offices of the Superintendent, Treasurer, Director of Operations, Board and Bargaining Units.
*SPECIFIC ROLE:* Overall Consulting of Benefits, Claim Expenditures, Reporting, Analysis and Regulatory Compliance

**Melinda Brown, Account Manager (Industry since 1993)**
Primary contact for Treasurer, Director of Operations, and Department Heads.
*SPECIFIC ROLE:* Group-Level Billing, Eligibility and Claims Disputes. Benefit Communications and Wellness Resources.

**Jennifer Lowis, Service Manager (Industry since 1995)**
Primary contact for Treasurer, Director of Operations, Department Heads and directly accessible to Staff.
*SPECIFIC ROLE:* Service contact for Billing, Eligibility and Claims Disputes.

**Kacey Grady, Vice President (Industry since 2006)**
Primary contact for Administration, Benefits and Payroll
*SPECIFIC ROLE:* Management of Ancillary & Voluntary Vendor Relationships.

**Chris Turoff, Pharmacy Analyst (Industry since 1997)**
Available for Pharmacy Related Issues and Analysis needed beyond the typical scope of work. Chris is an internal analyst but can be available for District and Committee.
*SPECIFIC ROLE:* Overall Consulting of Pharmacy Benefits, Reporting, Analysis and Regulatory Compliance

**Detailed Team Member Background:**

**K. Joseph Grady, President**
Joe graduated from The Ohio State University in 1994 with a B.A. in Economics. He was a founder of Grady Enterprises in 1996, leaving Group Benefits Agency, where he started in 1994 with a focus on employee benefit plans. Joe has served on the National Association of Insurance and Financial Advisors (NAIFA) Board of Trustees as Association of Health Insurance Advisors (AHIA) Chair. He is also a member of the National Association of Health Underwriters.

Joe is the primary point of contact for all major clients and is involved in all services provided. Responsible for financial analysis of funding and claims, monthly reporting, monitoring network discounts, requests for proposals, contract disputes and appeals, analysis and negotiations of administrative fees, stop/loss premiums, reimbursement schedules, renewal calculations, age factors, discount guarantees, network availability, subrogation, performance guarantees and terminal liability issues.

Report on State and Federal Reforms, National Trends and cost containment opportunities, facilitates on-site employee benefit education meetings, benefit committee meetings, and on-call availability to HR/Benefits Personnel and Union Representatives.

**Melinda Brown, Benefits Consultant**

Melinda attended Hocking College and began her insurance career in 1993. Melinda worked as an independent broker before joining United Healthcare as an Account Manager. Melinda joined Medical Mutual in 2003 working with Government and Labor Employers, becoming Client Director for the Division. Melinda joined Grady Benefits in 2018 to manage key-account portfolios.

Melinda will be the assigned Account Manager and involved in the overall management of the account. She will manage the implementation process, enrollment, and educational meetings. She will also provide information on new products and opportunities to enhance current products. She will be available for all ongoing support of programs and administration, including Health Plans, Ancillary Benefits, Cafeteria Products, Wellness Initiatives, Educational Seminars, EAP Coordination, and other directives of the Employer.

**Jennifer Lowis, Service Manager**

Jennifer began her insurance career in 1995 where she served as Account Service Manager, Eligibility and Customer Service Processor, and Customer Service Quality Analyst for United Healthcare. She joined Grady in 2004.

Responsible for customer service issues to include claims, billing, eligibility, employee communications, and other directives from committees. Jennifer will be the designated contact for HR, Benefits and Payroll Departments and is customer service contact for individual members.

**Chris Turoff, Pharmacy Analyst**

Chris graduated from The Ohio State University with a Bachelor of Pharmacy in 1991. He is an Ohio registered pharmacist with 33 years of retail, PBM and Health Plan pharmacy experience.

- Director of Pharmacy for MediGold, a Medicare Advantage Health plan.
- Director of Specialty Solutions, Accredo (Express Scripts Specialty)
- Senior Director of Clinical Services - Health Plans, Express Scripts
- Manager of Managed Care & Physician Service Center, Medco
- Supervisor of Customer Service Pharmacist, Merck-Medco Rx Services
- Independent Retail Pharmacist

Chris assists with RFP's, Contract Discussions, Strategic Initiatives and ultimately is involved in high-cost member-level management strategies.

## 3. Describe the core services that are typically provided to your clients, and indicate services some clients need that are outside of that core scope.

**This is a Summary Scope of Service Categories that are available to customers. We provide all the services requested in your RFP Services Section. The following is a list of Core Services included in our contract, as well as some additional services.**

## Outline of Services

The ongoing services provided to the District will include the following services pertaining to and involved with managing a self-funded insurance program.

- Review of Summary Plan Document (SPD)
- Review of Administrative Service Agreement (ASA)
- Review of Specific Stop Loss Agreement
- Review of Aggregate Stop Loss Agreement (Excess Loss)
- Monthly Evaluation of Claims Data
- Monthly Accounting of Funding to Claims Ratio
- Monthly Analysis of Expended Administrative Fees
- Review of Benefit Certificate
- Quarterly Claims Analysis with Carrier
- Attendance at Insurance Committee Meetings
- Preparation of Request for Proposal (RFP)
- Plan Design Analysis and Cost Containment Recommendations
- Comparison of Funding Alternatives
- Plan Design Savings from Deviation in Benefits
- Provider Discount Analysis
- Prescription Drug Analysis
- Financial and Funding Analysis
- Enrollment in Insurer System Access for Employer
- Monitor Provider Negotiations with Carrier
- Assistance for Individual Claims Issues, Disputes and Appeals
- Coordinate Actuarial Services for ORC 9.833 Compliance (audit fees not included).
- Available as Requested by Board of Education for Reporting
- Report on National and Local Trends, Legislation and Reforms
- Renewal Analysis for Medical, Prescription and Dental
- Advise and Educate on any other Product or Strategy
- Coordinate Wellness Programming Data Integration as Available
- Provide Materials and Data as Requested for Purpose of Union Negotiations
- Coordinate Dependent Audits (audit fees not included).
- Grady Enterprises does not provide direct legal counsel. Please seek legal advisement on matter of law.
    - Provide assistance in compliance and adherence to “Best Practices” mandates (Ohio Department of Administrative Services and SERB).
    - Provide assistance in compliance and adherence to COBRA, HIPAA, ERISA and other regulations related to insurance.
    - Provide assistance in compliance and adherence to Affordable Care Act Requirements (tracking and reporting service fees not included).
- Any Additional Services not listed above as determined to be within the general scope of work as above.

**ANALYTICS**
Financial and Claim Data Analysis are crucial to the sustainability of any group health plan. It is not enough to merely have information. Being able to develop that information into a study of trends, cost-drivers, and comparative benchmarking is the key to meaningful analysis.

**AUDITS (Internal and External)**
Grady administers and facilitates audit services as required, recommended by summary analytics, or discovered in agency review. Claims Audits will be provided for payment accuracy, verification of carrier discount guarantees, benefit compliance and confirmation of drug rebate values. Other audits may include requirements for ORC 9.833 (self-funded plans) dependent eligibility, and various systems integration.

**COMMUNICATION & EDUCATION**
We understand the importance of benefits to the public sector. More than in the private sector, employees view benefits as an extension of salary. Public Employers must provide benefits that can attract quality employees in a competitive environment. We participate in union negotiations at the request of insurance committees, boards, and union groups.

We believe our role, as a consultant, is to inform and advise our clients. We provide options and explore the advantages and disadvantages of each option. Through this education process, our customers can make educated and informed decisions based on the District and employee needs. When our clients are empowered with understanding, we can advocate their positions to insurance vendors and negotiate on their behalf.

Communication and Education must extend to the end-user, the employee. Understanding how benefits are designed creates an informed consumer and a partner for cost-containment. Wellness Initiatives can be short-lived without a direct and targeted communication campaign. Grady will provide the marketing materials and staff support you need for an effective wellness program.

**JOINT PURCHASING**
We remove the limitations when it comes to procurement of products and services for our customers. We evaluate placement in Risk Groups, Stop-Loss Pools, Consortia, Fully-Insured Alliances, Dental Trusts, Group Life Insurance Pools, Pharmacy Carve-Out Programs, and any available option to the employer.

**RENEWAL & RFP SERVICES**
We recognize that competitive bidding is a valuable tool and necessary due diligence in the public-sector. Our goal is to provide alternatives that will benefit employers, and the employees they represent, in both the short term *and* the long term.

**WELLNESS SERVICES:**
As one of the last frontiers in claims cost controls, Grady incorporates targeted wellness services within all our client benefit plans. While wellness has become a popular topic in the industry, Grady bridges the gap on a lack of coordination between programs and data integration.

Our goal is to engage employees and dependents in effective programming that provides consistency without aversion. In the end, you should have a program that shows evident savings, not just an estimated return on investment.

We will assist in the development, implementation, and on-going management of an employee wellness program. The program's goal is to create a culture of health and wellness by educating employees to consciously make healthy lifestyle choices that will reduce healthcare costs, improve morale and productivity, while decreasing absenteeism, turnover and long-term insurance costs.

**TARGETED WELLNESS**

Grady Enterprises takes wellness to the next level. We believe that wellness programming should be targeted directly toward trending of identifiable and prevalent conditions. Targeted Wellness can transform overall wellness programs.

Grady Enterprises will assess the appetite of the group and staff for more incented wellness programs that can accelerate the total population health management. While some programming may need to be reviewed with collective bargaining (such as employee contribution percentage based on risk-scoring); there are multiple facets to wellness that can be studied for implementation.

**COMMUNICATION SYSTEMS**

We strive to deliver essential time-saving and administrative advantages to our clientele by offering:

- Employer and Employee Benefit Portals, which can also include hard copy benefit booklets for all benefits.
- Online Enrollment Service, which can include enrollment of core (medical, prescription, dental) and any additional fringe benefits.
- On-site Employee Education Forums
- Personal Claims Assistance for Employee Issues
- HR Assistance and Compliance Forms
- Dependent Verification and Audit Services

**ENROLLMENT & BENEFIT ADMINISTRATION PLATFORMS**

Grady will help to coordinate the Employer Administrative functions of employer enrollment platform or insurer portals. We can also help evaluate platforms and services for this administration as needed. (See Cost Proposal)

**ABSENCE MANAGEMENT SERVICES and ELIGIBILITY CONSULTING**

Although often overlooked, this single aspect of our agency's services can provide significant savings to any employer. In many cases, collective bargaining agreements have been misapplied and coordination of leave of absence (LOA) policies is difficult to manage. Note: Full-service absence management is outsourced for fee (See Cost Proposal if requested).

We continually seek to provide more accurate and preventive measures in the products we provide. We can offer tracking tools to record absenteeism. Consistent monitoring of potential disability situations can allow for proactive response to an individual seen as a potential claim.

Integrating the wellness and disease management programs of the medical, EAP, or other benefits can also help to deter prospective claims.

*For example, implementing musculoskeletal or back pain factors into wellness programs and integrating with paid medical claims data may show an increased need for specific disease management programs.*

**PRODUCT DEVELOPMENT**

When we need specialty products to integrate with our customers, we develop our own products. Educator Disability Products were developed to provide custom benefits and offsets to Retirement System benefits phased-in over years of service. The Benefit Enrollment Platform is a product of internal development. Our ACA Vendor is integrated with State Software for ease of data transitions.

**SERVICE**

Service is the center value of our firm. We recognize that public sector clients place more value on their employee benefits; and as such, demand more interaction than most private – sector employees. We act as an advocate for every member of the benefit plans and their families.

**COMPLIANCE**

Although unintentional, Insurance Contracts are almost always in violation of some Board Policy, Employment Contracts and/or Union Agreements. As we have the opportunity to review hundreds of benefit certificates from public entities, we know the common discrepancies that can be found in public entity plans. The simple solution is that these situations must be reviewed and then disclosed or removed.

Example One: Many ancillary products are rated on 100% Participation, yet Employers have a coordinating policy that prohibits “dual-employee marriages” to enroll as family. This constitutes a “waiver” of one employee that is not permitted under the insurance contract. Remedy is disclosure.

Example Two: Benefit Limitations by age-reduction schedule on life insurance are often omitted from employment contracts or collective bargaining agreements. The remedy is that reduction schedules should be stated in employment policy or removed from the insurance certificate.

**HISTORICAL AUDIT & REVIEW**

At the initiation of a contract with any customer, we provide a thorough review of present policies but also review any past policy documents that can be made available. This assists our agency in understanding the history of a group and changes that have been made, recommended or declined.

The Scope of Services we offer our clients continues to grow. Services and Strategies consist of:

Core Services:

- **Consulting Services:** Client Review and Analysis to determine more effective plans design and funding alternatives. Analysis includes Medical, Pharmacy, Self-Funding, Stop-Loss, Risk Management Solutions.
- **Brokerage Services:** Clients are offered complete Request for Proposal/RFP Services for a competitive bidding of any benefit program. The RFP is performed in an open and engaged format to involve the Employer and Bargaining Membership.
- **Negotiation Services:** Clients are educated and provided with viable options for discussion and consideration during contract negotiations.
- **Consortium Evaluation Services:** Clients that participate in a consortium or are considering participation in a pooled contract are educated on the different contract types available so they may make an informed decision on entering or separating from a consortium plan.

Some common Individual and Collaborative Strategies for school customers:

- **Medical Alliance:** Fully-Insured Groups receive State Premium Tax Exemptions.
- **Medical Self-Funded:** Self-Funded Groups receive pooled-fees for Administration and Disease Management Programs.
- **Pharmacy Carve-Out:** Self-Funded Groups may utilize a Stand-Alone Pharmacy plan; covered under a Pharmacy-Only Stop-Loss Policy.
- **Stop-Loss Carve-Out**: Options outside of your TPA's Integrated Offer.
- **Life Insurance Cooperative:** Guaranteed Basic Life and Voluntary Life Rates with Enhanced Benefit Provisions.
- **Dental Insurance Administration:** Administration Pooling & Guaranteed Discount Savings Programs.
- **Disability Insurance Program:** Benefits to complement Public Pension Benefits.
- **Vision Insurance Platform**: Dual Offering of Multiple Networks.
- **Student Accident Plans:** Student Population Benefit or Student Athlete Coverage.
- **Section 125 Administration Compliance and Voluntary Products:** Coordination of Service Providers and Product Offerings.
- **ACA Compliance:** Service Software for Measurement and Stability Period Tracking and IRS Section 6055/6056 Reporting. Coordinated within USPS State Software.
- **Telemedicine Platforms:** Offered Stand-Alone or with Medical Consult-Charge Only.
- **Absence Management:** Administration and Tracking of FMLA/Sick-Leve Benefits.
- **Wellness and Disease Management Strategies:** Integrated and Stand-Alone Strategies that create a focused wellness program that directly impacts health plan care coordination modules.

## RFP Request to indicate services some clients need that are outside of that core scope:

We generally find that our "Core" Services will include areas not addressed by our competitors. We are extremely hands-on and will involve ourselves in any area, concern or issue that the District needs our assistance. You will not hear our staff say, "we do not handle that". Even if it is not part of our scope, we continue assisting you in finding the right contacts and ultimately follow-through with a solution for you.

**Some specific areas that can be outside the scope of benefits are:**
**Negotiations** – we are very proactive in making sure benefit contracts are discussed by committee and reviewed for potential impact or issues. Having options in clear language will help prevent future conflicts of interpretation. Legal counsel will have final language, but we assist with helping language coincide with any administrative issue internal to the plan.

**Enrollment Platforms** – Many consultants will leave this to an outside vendor and then want to have no interactions on behalf of the District. We find ourselves being part of many enrollment platform discussions to make sure the plan rules are followed correctly. An improper benefit enrollment can have a rippling effect that causes members to not receive the benefits they have negotiated or cost the plan for incorrect applications.

**Member Issues** – All of our competitors will argue they have great customer service as part of their standard scope of services. What you will see is a more of a liaison-service, where you send your issues to the broker, who simply forwards to the insurer for a response. That insurer-response is then forwarded back to the member. They will accept the insurer's response and forward that to your member. Forwarding emails between two people does make you an advocate for the member; and rarely gives the member an answer that includes explanation. Our office is trained to provide the answer, provide the explanation, give all possible options that members have available – and then continue to service that member through their issue. This is a difference you will see if you hire our agency, and this should be something you hear from our references when you contact them.

## 4. Describe some of the process, tools and resources that you would use in the analysis of potential solutions and prospective vendors for SCSD.

The biggest differentiation for our agency is that we prepare an RFP in a way that it can be issued; and then responses can be deconstructed to remove the assumptions and disparities within those responses. While their responses may be accurate, there are always assumptions made, specifically within pricing components.

In most cases, the PBM is responding truthfully, and then hoping that YOU will make the incorrect assumptions.

A good example is a Drug Rebate Amount. If you currently have a $200 Minimum Rebate and you are quoted a $220 Rebate, the PBM quote presents something perceived as better by $20. That is not true if your minimum rebate of $200 averages $240 in earned rebates. It is also an unfair benchmark if one PBM does not rebate the same scripts (excludes some scripts from the rebate guarantee).

Pharmacy repricing is an exercise that everyone uses but very few will take the time to deconstruct the data. Again, responses may be accurate, but there are always assumptions made where 'savings' is inflated or based upon alternate measurements (not as requested in the RFP). This is especially true in pharmacy analysis where responders may count on the difficulty (and quantity) of data points being repriced.

Our RFP Process will focus on many areas including:

- Benefit Plan Deviations
- Cost Comparisons (Administration, Discounts, Rebates)
- Pharmacy Claim Repricing
- Clinical Management of the PBM (and then enhanced services are added)
- Network Access, Retail-90, Mail Order, International Sourcing
- Formulary Disruptions (applied back into actual utilization).
- Specialty Medication Resources
- Coupon and Copay Assistance Management

Our RFP will flush out the most important aspects of each PBM and focus on Price, Clinical Management, Access to Care, Customer Service, etc. We have experienced team members that have worked within the PBM's and understand how the pricing is being presented, how the contract language needs to be corrected and how to find the most impactful management for member utilization.

We have a variety of team members that will interact with the District. All our team members are involved in pharmacy strategies for employers down to the individual members of your staff that we consult with each day.

**Pharmacy Specific Team Members: PharmAssist Consulting Group**
Chris Turoff is an Ohio registered pharmacist with 33 years of retail, PBM and Health Plan pharmacy experience and is a result driven leader, focused on driving down the cost of drugs for your group and members. He will assist in strategic initiatives and is involved in claim analysis for routine and high-cost member-level management.

We have engaged Chris as an independent consultant, after serving 8 years as Director of Pharmacy for MediGold, a Medicare Advantage Health plan. He has also served as:

- Director of Specialty Solutions, Accredo (Express Scripts Specialty)
- Senior Director of Clinical Services - Health Plans, Express Scripts
- Manager of Managed Care & Physician Service Center, Medco
- Supervisor of Customer Service Pharmacist, Merck-Medco Rx Services
- Independent Retail Pharmacist

**Process Differentiation:**
As mentioned above, most RFPs are variations of only 3-PBM's (Express Scripts, CVS/Caremark or Optum). The consortiums and coalitions use these same 3-PBM's as an Access/Aggregator. For example: You may have 3-unique proposals from RxOhio Collaborative, Medical Mutual, and a Local Consortium; but all 3 of these proposals are still through Express Scripts.

Our RFP Process focuses on different areas, which we generally call Price Transparency. Within any RFP, it is very important to first make sure you know current pricing. This can be more difficult than simply running reports on utilization. We want to create a comparable that is accurate and then weighed to cost drivers of the plan. The process varies depending upon the current information, but generally breaks into the following areas:

- Data Validation
  - Pharmacy RFP's fail when the incumbent data is not complete, accurate and transparent.
- AWP Determination
  - All "Discounts off AWP" are not the same. To make an accurate comparison, this needs to be adjusted for valuation where necessary. 30% Discount to AWP for PBM-1 may be better savings than 35% Discount to AWP for PBM-2.
- Discount Pass-Through
  - The pass-through of discounts full or percentage-based, per claim fees, clinical fees, and percentage of savings fees can all be elements of the pricing contract. Getting to the core-comparable can be very difficult if you are not looking for every detail of the contract.
- Rebate Applications
  - Most groups will spreadsheet the rebates as a comparison but then forget to apply the rebate. Most PBM/Insurer responses will not include this, because they know the tendency is for a broker or group to apply the rebate broadly. We mentioned the previous example of comparing a Rebate vs a Minimum Rebate, but there are other items that must be valued correctly for comparison.

    For example: If there is a $1 Rebate per Brand-Name Retail Script
    Most will use current pharmacy reporting and see that the group had 12,000 Brand Name Retail Scripts. They then apply the proposed rebate (example $1 Rebate) and determine the rebate value is $12,000. However, many PBMs will only apply rebates to "rebate-eligible" scripts. Determining how the PBM/Formulary design designates rebate-eligible scripts can change the valuation significantly.

While we do maximize rebates, we also want to keep in mind that our true goal is to reduce the amount earned on rebates by increasing the use of generic mediations (that do not generate any rebate).

Our agency is very focused on Pharmacy because this is where the utilization and trends drive the cost. While it is important to have an overall clinical strategy, these are the three biggest areas of focus and cost for all our groups. There is an absolute struggle for groups to find balance of cost and care. Cost is unsustainable, but the treatments that are available can be life-saving to your members. Groups have been challenged to manage pharmacy costs while ensuring optimal patient outcomes and meeting the needs of your members (and their families.

We feel a successful strategy must be Top-Down and Bottom-Up.

- Top-Down is where we rely on the PBM, the Clinical Programs, the Plan Design and the strategies below to guide members in these areas.
- Bottom-Up is where we engage the members directly in these areas. Even the best-intentioned strategy can be confusing or considered adverse to the patient. Education and Exceptions are crucial when implementing these very targeted strategies.

**Top-Down Strategies:**
We implement a variety of strategies with any PBM (or separate program model) to set the guidelines and help manage these areas. We rely upon the PBM to implement and enforce these programs. However, this does not mean we simply walk away and assume everything is going to work as we intended. Here is the quick list of items we will review in RFP as Clinical Strategies:

**Specialty Drugs**:

- **Prior Authorization (PA)**: Implementing PA requirements for specialty drugs ensures that they are prescribed appropriately. This step helps control costs and promote evidence-based utilization.
- **Step Therapy**: Consider a step-wise approach where patients start with lower-cost therapies before progressing to more expensive specialty drugs. This helps manage costs while maintaining efficacy.
- **Formulary Management**: Regularly review and update the formulary to include clinically effective specialty drugs while excluding excessively costly or redundant options.
- **Patient Assistance Programs (PAPs)**: Collaborate with manufacturers and foundations to provide financial assistance to eligible patients, reducing their out-of-pocket expenses.
- **Negotiating Rebates**: Collaborate with pharmaceutical manufacturers to secure favorable rebate agreements. These rebates help offset costs and improve affordability for payers.
- **Preferred Networks**: Create high-quality preferred networks of specialty pharmacies. These networks ensure efficient distribution and adherence to treatment protocols.
- **Home Delivery and Specialty Pharmacies**: Offer more affordable channels, such as home delivery and specialty pharmacies, to enhance patient access and convenience.
- **Clinical Pathways**: Develop evidence-based clinical pathways for specialty drugs. These pathways guide treatment decisions, optimize outcomes, and manage costs.

**GLP-1 Drugs** (used for diabetes management): Requires Diabetic Diagnosis

- **Preferred Formulary Placement**: Designate specific GLP-1 agonists as preferred options on the formulary. This encourages prescribers to choose cost-effective medications.
- **Dose Optimization**: Ensure that patients receive the appropriate dose based on their clinical needs. Avoid unnecessary dose escalation.
- **Therapeutic Substitution**: Consider substituting a high-cost GLP-1 drug with a more affordable alternative within the same class.
- **Patient Education**: Educate patients about the importance of adherence, lifestyle modifications, and proper administration of GLP-1 drugs to maximize their effectiveness.

**GLP-1 Drugs** (used for weight-loss): Diabetic Diagnosis NOT Required

- **Criteria of Medical Necessity**: Some groups allow coverage of these medications based on "weight-loss". These medications are very desirable as lifestyle medications, and it is important to set very specific prescribing requirements (Example: BMI or Pre-Diabetic Diagnosis).

  **This is also becoming a very active conversation within groups that do not cover these medications for weight-loss.** In the current environment, these medications are cost-prohibitive for most plans. There is also a supply issue with these medications, and expanded coverage is arguably causing increased cost for Diabetic members that need these medications.

  However, there is a lot of discussion about the cost-benefit to allowing these medications to be more available to members. The ability to reduce weight within our entire populations has a 'wellness' impact. Like Humaira In the past, these GLP-1 Medications will expand their use and effectiveness to other areas, for example these medications are being used for heart disease. Groups should be having these conversations proactively and continuously.

**Gene-Cell Therapy Drugs**: This is a limited, yet extremely high-cost area that goes beyond simply cost. The Gene-Therapy strategy needs to consider the plan and the member, but also the stop-loss and overall risk components of a plan.

These medications are life-changing and in many cases life-giving. Conditions and Treatments like these remind us of the purpose of insurance and all members would expect to have this level of care if they needed it. The PBM and our office will work together and support coordination of care and coverage for these members.

- **Coverage Criteria**: Establish clear criteria for coverage of gene-cell therapies. Consider factors such as disease severity, patient eligibility, and evidence of clinical benefit.
- **Risk-Sharing Agreements**: Explore value-based contracts with manufacturers. These agreements tie reimbursement to real-world outcomes, ensuring cost-effectiveness. The PBM will work through the primary cost, but our agency will make sure this risk is covered under stop loss to mitigate the exposure to the group.

- **Centers of Excellence**: Designate specialized centers for administering gene-cell therapies. This ensures proper handling, monitoring, and patient safety.
- **Clinical Pathways**: Develop evidence-based treatment pathways to guide prescribers in selecting appropriate gene-cell therapies. There are very strict guidelines for these medications, so helping candidates navigate this approval is one area where we assist your members that may be considering (or need) this level of treatment.

**Bottom-Up Strategies (Member Engagement):**
Everything mentioned above is very important for a successful program. We also know that members are doing what they think is best, and that does not always align with the plan-strategy. In many cases, members do not know their options. They are not intentionally making bad choices; they just did not know there were any options.

We diligently dig through claim details to find areas where costs might be avoided. In some cases, this is the best or only course of treatment, and the cost cannot be avoided. We often do not know this until we have a chance to talk with a care-coordinator, review medical notes and/or speak to the member directly.

Customer Service is our greatest tool. All your RFP responses will talk about high-levels of customer service. Our team is very experienced, and we give members one point of contact for their individual service needs. In a short time, your membership will know they have an advocate for any insurance issue. Incidentally, these are often the same members we are focusing on outreach. When a member is having trouble with a prior authorization or a pre-certification or obtaining a specific medication – they contact our office. While we advocate for the members, this is also our opportunity to discuss alternatives and cost-savings.

In RFP Responses like this, we share stories of members contacting our office because they are on Specialty Medications and need infusion coverage. These are real-life examples of $38,000 per month facility infusions (8 per year at $304,000) where we can ask the member if they would rather have this treatment in their own home. Many did not know that was an option, or their physician only refers them to using their own facility. Most members prefer home-infusion, and the cost (for this member example) was $5600 or $44,800 per year. The member made the choice of convenience, but the plan saved $259,000 on just one member. It also significantly impacts stop-loss coverage and premiums.

We share stories like this one, because it is simple and significant savings. What is more important is that we look for nickels and dimes too. Every area for savings is explored and promoted whenever possible; and wherever we have direct interaction with your members. We set the plan top-down for guidance and even outreach calls or mailers. The bottom-up approach is where we make a difference on member engagement through education.

We also spend the time looking for High-Cost Medications that ae being sourced through the Medical Plan (and are not submitted through the Pharmacy Plan Clinical Program edits). This is an area where plans can miss significant impact.

- Most prescriptions are run through the pharmacy benefit. The claim is processed at the point of sale. You have a prescription, the pharmacist checks your coverage, the pharmacy receives your payment and provides you with the medication. Any strategy guidelines are applied before the transaction is completed.
- Medical pharmacy runs through the medical plan. In many cases, the process of order changes because the claim is not processed at the point of sale (when it is administered). You are in the facility, they may check your coverage or submit a pre-certification, they provide you with the medication; and then the claim goes to the medical plan for processing. Any strategy guidelines become ineffective after services are provided.

Medical Plans rely on the pre-certification process, which is not always timely or accurate. By the time this claim needs to be managed, it has already been administered. Systems need to be set up ahead of time for sourcing, pricing and then delivery of medical pharmacy. As a simple example, medical plans may not have the pricing that is readily available through your PBM. Allowing the provider to obtain medications and then administer those medications means that the medical plan contracts are used for pricing. In certain cases, the member can obtain the medication through their pharmacy benefit at better pricing and then have their physician administer the benefit.

In some instances, we find the provider may take advantage of the medical pharmacy process to charge for medications that would be excluded under a pharmacy strategy. As an example, we had a school district where a local podiatrist was billing over $1000 for office visits. Upon review, the office visit included administration of a pain medication (for foot pain). The medication was Duexis at around $800 for a 30-day supply. This medication would have been excluded under the plan's pharmacy benefit because it is ibuprofen covered famotidine (Pepcid/Antiacid). These two separate medications are available over the counter for around $30. The $800 medication claim was paid by the medical plan as part of the office visit. These can be identified and stopped, but the best strategy is to stop this from occurring at all.

## 5. What trends do you see in employee benefits?

Increased Cost & Inflation – More than in prior cost cycles, we are seeing acceleration in costs. Costs are ultimately passed on to the customer, and they come from every direction.

**Employers are now forced to make very tough decisions about their benefit plans.**

- **Unique Products and Funding Alternates:** Insurers are developing new benefit plans that expand upon the HDHP, HRA & HSA Model Plans.
    - **Self-Funded with HDHP Plan Option -** District is already Self-Funded and utilizing the High-Deductible Plan Model. **This plan can be very successful if it includes significant employee engagement.** Benefit Education opportunities are critical. When members do not understand the mechanics of the HDHP plan-design, there is a perception of lesser value. When members are comfortable with the benefit, they see the advantages of the plan that are being afforded to them. These plans can have extremely high satisfaction rates if you provide the correct tools and continually engage the membership on how to use those tools. Our office excels at communication and education at the member-level.
    - **Stop-Loss Sharing** is also a new model that can help protect the group. There can be a cost, but public entities tend to fund their plans on a "worst-case" basis. This limits the total liability, which allows public employers to set funding rates closer to the expected cost (not overfunding for potential cost).

- **Limited Networks:** Employers have been looking at smaller networks to achieve greater discounts. There is member disruption here, but in many cases a group already has a majority of utilization within one regional system.
    - It is also important to note that we are seeing this at the Insurer/Carrier Level. Contract negotiations are becoming more aggressive between the insurers and providers. The trend is moving toward limiting the networks to achieve savings, and your members may not always have access to some provider systems.

- **Direct contracting**: with a provider can be advantageous but is not always as easy as it should be. For most groups, this is only done on small-scale or case by case for specific services. Often a smaller PPO Network can drive pricing in a specific area or with specific providers. When it comes to a stand-alone employer, direct contracting can still work. We see it in primary care where we can institute a clinic model where services are 'unlimited' and reimbursed as a PEPM Fee (Per Employee Per Month).

- **Onsite or Near-Site Clinic Models** are popular but require some steerage of the plan to make an impact on cost. The District location allows for wide access to care, and there would be an opportunity to direct and focus care to the most efficient providers in the area. Working with those providers to find solutions can benefit all parties.

- There is a trend towards better management of High-Cost Claimants. **High-Cost Claimants are unavoidable, so good management is important.** We can talk about prevention and wellness, but we still don't have answers to many diseases like cancer, or complex pregnancies, or accidents. When discussing high-cost medical claims, the plan must provide coverage for services used for proactive identification and early detections. The plan must offer Access to Quality Care and that may include a 'Center of Excellence' for specific conditions. Then, the plan must be able to focus on care-coordination and extended services to help with ongoing treatment programs. Here are some effective strategies for managing high-cost claimants:

**Preferred Providers, Specialty Providers and Nationally Recognized Treatment Centers as Centers of Excellence**:

- Encourage employees and their families to seek in-network, nationally designated facilities for diagnosis and treatment. These centers may have more upfront cost but offer specialized care and expertise to potentially reduce recurring costs and improve outcomes for members.

**Proactive Identification**:

- Preventive Care, Annual Physicals, Expanded Lab Testing Coverage for Early identification allows for targeted interventions and better care management.
- When available, lab data and other claim analytics are used to predict which members are likely to become high-cost claimants.

**High-Intensity Case Management**:

- Assign dedicated case managers to high-cost claimants.
- These managers advocate for high-value patient care and address medical bills proactively. These managers can also provide resources that the members may not know to be available. Our office can work with case-management when members are questioning coverage.

**Cost Management**:

- Continuously monitor and analyze claim costs against benchmarking. Benchmarks for pricing also includes benchmarking common treatment plans or procedures.

**Intervention with Membership:**

- While this can initially seem like an invasive approach, there is now more support from membership to have direct intervention with their care. It must be done outside of the employer, but members are willing to accept help and look at recommendations that can provide better care and save money. As an example, members that have infusion therapies can see very high costs, and inconvenient care models. We find this to be excessively true in areas with limited competition for this type of care. Where possible, we use a regional network of providers for home-infusions. This can be voluntary, or the plan can force this service under plan design.

  Where members are unable or unwilling to use home-infusion care, we can look at alternate facilities. Even in areas where members do not have options, it can be cost-effective to use further facilities and cover transportation. In our earlier example, we discussed a $38,000 facility infusion that we transitioned to a $5600 home-infusion. This member changed voluntarily, but there was a second-option where the plan can designate a preferred service provider in another area. In this case, it was 1.5 hours to the preferred provider, but the plan was willing to provide transportation to save $32,000 each treatment.

**Pharmacy Carveout vs Integration:**

- There has been a trend to carve-out pharmacy management. This was a direct result of the Medical Plans using the pharmacy revenue to subsidize their costs, taking savings away from the employer. In recent years, the Medical Plans have realized they need to be more competitive in Pharmacy (meaning they needed to pass more of their savings on to the customer). This has led to better overall management with integration of the utilization. There is still an impact on stop-loss, and carveout pharmacy can have great advantages if the employer is looking for a more comprehensive pharmacy program.

**School District Trending:**

- While there are many trends in healthcare overall, there are also many trends that that come through school districts. The advantage of our agency is that we are involved with schools around the state and see what is being implemented in benefit programs of your peer groups. This trickles down to Eligibility, Collective Bargaining, Plan Options, Waiver Incentives, HSA/HRA Plans, Premium Contributions and more. We guide these conversations in a clear and transparent manner, making it easy for agreement, compromise and communication.

## 6. How is your firm becoming an expert and helping your clients with these trends?

While I would refer to some of the details in questions 4 & 5 above, I would also say that our expertise has been developed over years of experience. Our team is consistent for your groups. We know that many of our competitors will present high-level staff in their RFP Response, and they will bring those high-level employees to Finalist Meetings and "Get the Sale". After the sale, they will "re-organize" staff to give you lesser-experienced representatives. With our office, you will get the team presented here in the RFP. You will continue to work with our key personnel that have the expertise to guide you through the changes in healthcare.

Conversation in healthcare committee becomes a balance of Fiscal Responsibility vs Personal Utilization. We can never forget that the insurance discussion is ultimately about an employee, a friend, a family member that needs care. Those conversations are tougher and tougher; but the discussion must be open and honest. Where can a District find control unnecessary cost, so that the plan is sustainable for those that really need care? A consultant should be able to have those tough discussions with your District. The GLP-1 dilemma facing plans today is not a new conversation. It is very similar to what employers faced in 2008-2010 with Proton Pump Inhibitors like Nexium (Acid Reflux Medications). The cost-benefit discussions were very sensitive, especially within collective bargaining agreements. We have also expanded our Pharmaceutical Approach because our experience is our expertise.

Internally, our office has requirements of staff: training sessions, advance licensing courses, continuing education and other areas where staff can continue to learn – but you will see that our on-the-job training allows us to identify emerging issues proactively.

## 7. What differentiates your firm from your competition?

**Our greatest strength as an agency is our ability to bridge gaps and create a transparent working relationship between stakeholders.**

As you interview different consulting firms, you will hear similar claims of industry knowledge, customer service and proactive engagement. We've made all these same representations throughout our RFP Response. The question is not what you can do, but how do you do it. How do you take everything on the resume and make it work for the customer? We think our core difference is trust and integrity. It sounds cliché, but we hope when you contact references and ask more than if we do a good job for our customers. We hope you ask if they trust our advice and ask if the union leadership trusts our recommendations. We hope you ask HR Department references if they trust that we will handle your employee issues to satisfaction. We hope you ask if they rely on our analysis and feel confident when relaying information to the Board. We hope you ask if the union leadership feels that they are empowered and knowledgeable about their benefit plans.

You can bring very smart people onto your committee, but there is no support if you feel that your consultant is working in their own interests (or the interests of one group over another). There is no support if you don't trust the information being presented or don't understand the information being presented.

We believe our role, as a consultant, is to inform and advise our clients. We provide options and explore the advantages and disadvantages of each option. Through this education process, our customers can make informed decisions based on district and employee needs. When our clients are empowered with understanding, we can advocate their positions to insurance vendors and negotiate on their behalf.

Our agency also strives to meet challenges with our customers. As you may see from many of our references, our agency often brought in for resolution management. For our existing clients, we maintain a proactive strategy to avoid these situations. Many groups are disconnected when it comes to direction, and the process to get to where you want to be in your benefit plans. There needs to be trust, transparency and strategic planning as benefits become more complicated to manage each year.

The difference is very subtle, but crucial for a district to make decisions on benefits. When all parties are involved in a decision, and feel they have accurate (and transparent) information; then then you function as a committee.

Given the opportunity, this agency will go above and beyond the comprehensive services requested and presented within this RFP. We will meet and exceed the current contract requirements, and we think you will see a difference in the way we interact with your District and your members. The challenges you face are changing daily and we believe that our experience in public education will prove of great value to you immediately and in the long-term.

## 8. What should we expect as a customer over the next 12 months?

We are an advocate for your group and the members you serve. We would ask that you request and reach out to our references. Not only the Treasurer or Superintendents Office, but the payroll and benefits contacts, the insurance committee members, the union leadership and any employee that has contacted our office. We are confident they will all tell you that our team responds quickly, accurately, and will continue to advocate for those we represent until there is a satisfactory answer provided.

Our teams are experienced, and we provide all core-services. We are a smaller agency than what your District has engaged in the past and you will notice the difference. We are engaged and we feel that our teams can close the gap between the group strategy and the member experience. Larger firms contend that there is better service when they have separate departments handling your account. With our agency, your team handles everything. We know when there is a recurring service issue that is likely a larger plan-level issue.

We can advise on all topics within the plan:

- Individual Service Issues are not sent to a call-center. Service is provided by the same team that helps develop the plan strategy and knows the intent of the group plan.
- Group Service Issues are handled by the Account team that sits on your insurance committee.
- Analysis is done by your account team. We do not have a department that runs reports and ships them to you. We run reporting monthly, review that reporting and share insights with the Group and committees timely. The person running your reporting is the same person that meets with you to review those reports.
- Renewals, Funding, Reserving, this is all done by your account team. While it is run through audit teams, it is not simply shipped out for response.
- There are situations where we may need legal clarification on issues, or we need more research for a response to your group. That said, everyone on your team will know your plan and they are experienced in the industry and the rules that apply.

- Further, our team for you has experience working with school employees. We understand that your time is valuable and scheduled (and we work around the school-day and planning periods). We understand the value of benefit plans to a member that may have negotiated to offset salary increases or given up take-home pay to choose the better plan options offered by the District.

## 9. Description of proposed compensation structure for these services

**Please See Fee Proposal Included with Sample Broker Contract.**

We have provided a Cost Proposal in Exhibits for Reference, and we are open to all discussions around compensation, disclosures, and services. We have based our initial fee on your current consulting contract, also included in the Exhibits for Reference.

### Notes on Fee Proposals:

**Terms:** We typically propose a 2-Year Fee Guarantee with a 1-Year Fee Renewability. The Fee Proposal included will show an initial 10-Months with start date of September 1st and is structured to end on June 30th for a Fiscal Year Based initial contract. This initial period can be shortened for a later start date if needed. The contract would continue as a 12-Month basis July 1, 2026 to June 30, 2027 with a 12-Months Renewability Provision July 1, 2027 to June 30, 2028. This was done for fiscal year accounting and renewability. We can be flexible to meet the needs of the District in any area of our proposal timeline or fee structure.

**Terminations:** Our most important area of flexibility is that our agreement includes a Termination Provision. If you are unhappy with our services, you are not locked into a contract or continued payments (after the initial contract period as noted in fee proposal).

**Inclusive Fees:** We are flexible if the group needs to make different fee arrangements. We included an inclusive fee that represents the services represented in the RFP Request. We can alter the fee to show project fees on as-needed basis. For example, we can provide an alternate fee for RFP Services that may only be done periodically. Or we can alter fees as a first-year versus renewal fee because we know the first year of the contract should always be the most work for our agency. While we have great experience with the District and have a lot of history, we also know that we need to review all contracts, board policies, collective bargaining agreements; and get the recent history of the District.

**Sample Contract Language:** We are flexible to assume current contract language everywhere possible. Our standard agreement includes a Broker Contract, Fee Schedule and then a Business Associates Agreement or Board Contract to outline specific roles, responsibilities, and other terms of the relationship. We can provide this document but prefer to work with documents from our District customers. Your internal documents have already been approved by your legal counsel and can make for a simpler (and less expensive) contracting process. We will review and work with your existing contracts as best possible to make the transition seamless.

**Fee for Service Model:** We are flexible in how compensation is structured, but we prefer a direct fee for service contracts. We use an annual fee, paid as monthly or quarterly installments. Our fee is developed from the scope of services.

Our agency fees are competitive, and we develop fees with a blend of annual fixed costs and anticipated Per Employee Per Month (PEPM) for the variable amount of service which can be directly tied to enrollment and users of the plan. Note: we do not invoice PEPM fees, we set all fees as a flat amount at the beginning of the contract for ease of invoice reconciliation.

The only arrangement that we do not use for compensation is a percentage of premium. We feel there is a conflict when our fee increases because your insurance costs increase. There is also a perceived conflict if our fee is reduced as we find savings for the District (which is the primary goal of our position).

**Fee Disclosures: The current and existing contract is not provide or available to match terms.** It is assumed that on the current and existing consulting contract acknowledges that consultant may participate in additional indirect compensation programs. It is currently unknown what additional compensation could potentially be earned if our agency was selected by the District. We will provide compensation disclosure when requested through 5500 Attachment-A from each TPA, Insurer, Stop-Loss Insurer, Wellness Program, Enrollment Portal, Cobra Administrator, etc. Any vendor that is doing business with you can provide confirmation of Grady Benefits compensation, direct, indirect, or none. The District is considered Non-ERISA and is not subject to 5500 Compliance, but the disclosures of 5500 Atachment-A can still be provided when requested.

**Fee Options:** Our Fee Proposal includes services that we would recommend. The District does have the option to limit or exclude these options, however the Grady Benefits fee will need to be adjusted if these Services fall within our direct scope. We feel it is important to have an outside review and audit or our recommendations to the District in these areas.

**Actuarial Services (ORC 9.833 Required Audit):** Please note that our office takes the position that the actuary providing audit services should be an independent third-party, and we do not use our own staff for this opinion. Grady Benefits employees will be recommending funding levels and providing underwriting services. There is an inherent conflict for another Grady Benefits employee to act as the actuary that audits and certifies reserve balances resulting from those same recommendations.

Our office will assist in procuring the Statement of Actuarial Opinion as required. We will work with the actuary to provide all necessary data and materials needed for the certification. We can include the cost of this service under our consultancy fee and make this part of our assumed core service requirement. We just wanted to clarify that we will use an independent actuarial firm to provide the report needed.

Our Fee Proposal includes pricing for Parsons Risk Strategies:

- **Stage 1 – Core: Actuarial Foundation**
  - Annual Audit for ORC 9.833 Compliance. This is the minimum service required to meet Certification with Auditor of State.
  - Actuarial Projections and Premium Calculations
  - Plan Design and Contribution Insights and Modeling
  - Actuarial Certification of Mental Health NQTL
  - Reserve analysis relative to risks and stop loss
  - Stop Loss Evaluation
  - IBNR Calculations
  - ORC 9.833 Actuarial Certifications
  - Evaluation of Funding Options (Self-Ins, Fully-Ins, etc.)
  - Retiree Medical Liabilities and Accounting
  - Compliance and Reporting

- **Stage 2 – Insights: Actuarial Forensics**
  - Stage 2 Forensic Services – Independent Review Services
  - Actuarial analysis and insights of claims experience
  - Large claims analysis – plan experience normal or an anomaly?
  - GLP1 Claims Impact
  - Emerging Potential High Cost Claims
  - Large Claims
  - Recurring Mega Claims
  - Changes in the market or region
  - Carriers and Providers
  - Funding History Analysis
  - Actuarial review of rate setting
  - Benchmarking insights

- **Stage 3 – Multi-year Actuarial Modeling and Strategies**
  - Stage 3. This can be instrumental in providing a long-term, written funding plan that can coincide with collective bargaining agreements.
  - Interactive Multi-year Actuarial Model
  - *Tool provided to client*
  - Multi-year Risk, Reserve and Stop Loss Strategies
  - *Written Risk and Reserve Strategies*
  - Multi-year Funding Strategies for Employer and Employee
  - *Written Funding Strategies*
  - Assist Modeling of Long-Term Employee Contribution Strategies
  - Assist Modeling of Long-Term Plan Design Strategies

Our Fee Proposal Recommends and Budgets to include this service as part of Grady Benefits Fee (which we will remit to Parson Risk Strategies)

**PharmAssist Consulting Group:** As described in our RFP Response, pharmacy is a focus area for our agency. While we have the internal structure to support this on our own, we would see additional value with PharmAssist on a group of your size. We have included this as part of our proposal and we have included some additional hours for the first 16-Months of the agreement.

**PharmAssist Consulting Group**

Chris Turoff, owner and President of PharmAssist Consulting Group, is an Ohio registered pharmacist with over 33 years of retail, PBM and Health Plan pharmacy experience. Chris leads a team of Pharmacists that focus on driving down the cost of drugs and ensuring proper utilization of the pharmacy benefit Chris and the PharmAssist team also bring extensive knowledge and experience in PBM contracting RFP process, formulary and utilization management development.

The PharmAssist team will review your members' drug profiles monthly to provide clinically based medication management initiatives that drive cost saving and better clinical outcomes through their Therapeutic Intervention, Therapy Duplication and a Gaps in Care programs.

**Therapeutic Intervention Program** focuses on optimizing patient medication regimens to improve therapeutic outcomes and reduce costs. In this voluntary employee centric educational program via informational messaging, our pharmacists assist the plan in educating your employees when lower cost therapeutic alternatives are available on your formulary where brand to brand, brand to generic or generic to generic opportunities exists, resulting in savings to your employees and the plan.

**Therapeutic Duplication Pharmacy Program** aims to identify and resolve instances where patients are prescribed multiple medications from the same therapeutic class, which may lead to unnecessary side effects, increased costs, or diminished effectiveness. By utilizing prescription data and clinical guidelines, our pharmacists review patient medication regimens to detect duplications and work to streamline therapies. The program enhances patient safety in hopes of promoting the safer use of medications and decreasing unintended use of urgent care and emergency room visits.

**Gaps in Care Pharmacy Program** is designed to identify and address unmet needs in medication-related patient care, improving outcomes and reducing healthcare costs. By leveraging data analytics, our pharmacists pinpoint gaps such as missed medications or suboptimal therapies, including statins for patients with diabetes and cardiovascular disease. They may also recommend medications to mitigate the worsening of chronic conditions such as congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). Like the Therapy Duplication program, the goal of this program is to reduce medical spend by decreasing hospitalizations and readmissions.

**Quarterly and Yearly Pharmacy Reviews** will be held quarterly at your regularly scheduled benefit meetings. During our three quarterly and annual reviews, we will respond to your pharmacy benefit inquiries and address the following:

- Provide insights into key drivers of pharmacy trend
- Identify significant contributions to cost and utilization changes and top drug/class analysis
- Identify members and providers driving the highest proportion of costs, determining the drug and/or classes associated with these members/providers
- Provide savings for the enrolled savings programs

With years of PBM RFPs and implementation experience, the team can be leveraged to ensure you secure a PBM contract with the most favorable terms and alignment of PBM's offerings with your organizational goals.

Our Fee Proposal Recommends and Budgets to include as part of Grady Benefits Fee (which we will remit to PharmAssist).
This portion of the fee is based upon 10-hours per month with 5-hours for special projects. PharmAssist Fee does not include cost of mail or postage of member correspondence if required.

## 10. Experience with self-funded health insurance plans

Our agency has a long history with self-insured plans. Historically, many consultants wanted to keep things fully-insured. Plans were simpler, less work, and bigger premiums meant greater compensation and bonuses. We have always put our clients first and looked to self-funding to cut cost. This does have the added responsibility of managing the risk involved, which we hope to have addressed within this RFP and you can see the great care we take in helping our customers.

Almost all our clients are Public Schools with self-funded plans. This includes many different strategies: Fully-Funded, Contingent Premium, Consortium Risk Sharing, Stand Alone Self-Funded and other alternative funding arrangements.

Self-Funded Plans are our preferred approach and allows an employer to really see cost-drivers. We also think it is very important for your membership to understand that there is a self-funded plan. Your members are their own insurer, and they need to understand that it is not them vs the insurer.

It takes some time and savings are gained gradually. There are very few "magic bullets" in healthcare. In the past, we could change the network for discounts, we could pay for a diabetic management vendor to mine data, we could change the drug formulary. In the past, we could make a couple big changes and see big savings; but those days have passed.

Today's insurers have more parodies and finding savings in healthcare is a grind. It is a day-to-day effort to save nickels and dimes across the health plan. The plan cannot expect this change to happen from the top-down, it must also come from the bottom to the top. A school district plan must be able to engage their membership in the process.

Some of this can be done through plan design, but ultimately each member has a different need for health care.

- Some members are healthy, we need to keep them healthy.
- Some members are unhealthy, we need to help them manage their conditions.
- Some members are in a health event, we need to be a resource for care.
- Most members are somewhere in between using preventive care and maintenance medications. This is the area where savings is achieved over the longer-term.

For the RFP, the alternate response to this question is that we do have modeling to project savings through plan changes and other program implementations. This is helpful in discussion and goal-setting, but the projection needs to be more than a one-time event, a one-time cost shift. Savings is achieved through a shift in how members use the healthcare system; the who-when-where-why-how we use healthcare. We will always be proactive and educate members, so they have a basis of understanding when ready to engage.

**One thing we know is that members usually wait to be engaged until they need to be.** When life changes and health conditions surface, this is where the members need to be met. Our agency does a great job in working with individual members to find the care they need within the plan and using cost-effective options wherever possible.

## 11. Experience with Ohio public school district health insurance plans

Grady Benefits has over 350 Active and Ongoing Clients. Many of these could be limited services where we may have an offering of specific services or products. This may include:

- Limited Consulting Engagements (RFP Services, Negotiation Services, Evaluation Services)
- Group Ancillary Products (Dental, Vision, Life)
- Group Voluntary Plans (Life, Disability).
- Benefit Compliance Tools & Resources
- 125 Plan, Cobra, ACA and other Compliance Services

- We manage cunty consortia plans that include multiple districts (and multiple unions represented within each District).
    - Athens County Schools Consortium
    - Hardin County Schools Consortium
    - META/OSC Fully-Insured Alliance

- We have a brief list available here, please let us know if you need specific references to contact:
- Gahanna-Jefferson Public Schools – 900 Employees
- New-Albany Plain Local Schools – 650 Employees
- Hamilton Local Schools - 300 Employees
- Franklin County Board of Developmental Disabilities – 600 Employees (was 1100)
- SERS /School Employees Retirement System -200 Employees
- Athens County Schools Consortium – 800 Employees (7 Groups)
- Hardin County Schools Consortium – 600 Employees (6 Groups)
- Jonathan Alder Local Schools – 275 Employees

- West-Jefferson Local Schools – 150 Employees
- East Muskingum Local Schools - 225 Employees
- Manchester Local Schools - 300 Employees
- Clear Fork Valley Local Schools – 250 Employees
- Pioneer Career Center – 180 Employees
- Van Buren Local Schools - 150 Employees
- Danville Local Schools - 100 Employees
- Cardington-Lincoln Local Schools - 125 Employees

- We also have general consulting for insurance programs offered through:
  - Ohio School Boards Association
  - META Purchasing Cooperative (Metropolitan Educational Council)
  - Ohio Schools Council
  - Special Projects and Trainings with ESC Central Ohio and OASBO

## 12. Experience with negotiated agreements and multiple union groups as part of a District Insurance Committee

We spent time discussing this in response to Item 7 above, but we do consider this to be one of the primary differences in what you will see with our agency in the role of advisor.

**Our greatest strength as an agency is our ability to bridge gaps and create a transparent working relationship between stakeholders.**

We know that every strategy, discussion, conversation, thought, plan or idea **will ultimately need to have the support of all stakeholders**. This is administration, board, union, HR Department, Benefits Department, Treasurer's office, Actuary, and the Membership that will rely on the benefits for their care and the care of their families.

Almost all our clients have a bargaining agreement that includes multiple unions; generally Certified, Classified, Administrative (mirror-agreement) and then there can be separate unions within classified groups. We also work with county consortia that have a common benefit plan across 6-7 Districts each; that is 14-16 unions making benefit decisions within the same plan. We are very good at setting expectations, explaining any benefit deviations, getting ahead of negative impacts that come with changes, and then providing member-education directly to staff. When all parties are included and part of the decision-making, there is broad support and confidence in the programs.

Note from our response above to item #7:

As you interview different consulting firms, you will hear similar claims of industry knowledge, customer service and proactive engagement. We've made all these same representations throughout our RFP Response. The question is not what you can do, but how do you do it. How do you take everything on the resume and make it work for the customer? We think our core difference is trust and integrity. It sounds cliché, but we hope when you contact references and ask more than if we do a good job for our customers. We hope you ask if they trust our advice and ask if the union leadership trusts our advisement. We hope you ask HR Department references if they trust that we will handle your employee issues to satisfaction. We hope you ask if they rely on our analysis and feel confident when relaying information to the Board. We hope you ask if the union leadership feels that they are empowered and knowledgeable about their benefit plans.

You can bring very smart people into your committee, but there is no support if you feel that your consultant is working in their own interests (or the interests of one group over another). There is no support if you don't trust the information being presented or don't understand the information being presented.

We believe our role, as a consultant, is to inform and advise our clients. We provide options and explore the advantages and disadvantages of each option. Through this education process, our customers can make informed decisions based on district and employee needs. When our clients are empowered with understanding, we can advocate their positions to insurance vendors and negotiate on their behalf.

Our agency also strives to meet challenges with our customers. As you may see from many of our references, our agency often brought in for resolution management. For our existing clients, we maintain a proactive strategy to avoid these situations. Many groups are disconnected when it comes to direction, and the process to get to where you want to be in your benefit plans. There needs to be trust, transparency and strategic planning as benefits become more complicated to manage each year.

The difference is very subtle, but crucial for a district to make decisions on benefits. When all parties are involved in a decision, and feel they have accurate (and transparent) information; then then you function as a committee.

## 13. Experience with Employee Care Medical Facilities

We believe this question is specific to the District's Employee Health Facility. We have experience with Onsite or Near-Site Clinic Models which have become popular again in recent years. This model was used before evolving into an HMO approach, which became the PPO and Managed Care based on Network Access. In the last 10-years, there has been a resurgence of this approach and many employers have developed or joined these type of arrangements.

With any program, the savings can only be generated when there is utilization at the clinic and the clinic is efficient. What does this mean for an employer:

**Utilization** is key for an Employee Clinic Model. The program typically has a capitation fee, per member per month (PMPM). That fee is paid each month, regardless of utilization. The only way to see a return on that PMPM Fee, is to see utilization through the clinic which is savings to the plan cost (absence of a claim at another higher cost facility). The plan should design an incentive that promotes steerage to the clinic through a better benefit (or a higher-cost when using an alternate facility). Many clinical models will provide the service, but the savings is not generated if employees do not use the clinic when appropriate.

Many of these facilities are located conveniently for an employee but may not be readily accessible to dependents that live in other areas. This should be addressed within any clinical model, and we often see that covered dependents (Spouses/Children) are higher utilizers than employees.

**Efficiency** is something that should be measured consistently. Unfortunately, the resurgence of the Employer Clinic is based on opportunity for revenues. In the past, the Employee Clinic was owned by the employer. The employer could set costs based on their savings. This model has returned in popularity because it has become a profit-center for private investors and many Brokerage and Consulting Firms. Privately owned Clinic Models are built so that the PMPM Fee is automatically increased based on the utilization. There is no potential risk to the clinic in this model, which they present with “you save when we save” description. Savings and ROI is often overexaggerated to promote the model, which really becomes another layer of expense to the plan.

The programs have great potential and should be encouraged and promoted effectively. There is room for margins to go undetected in these programs, so an audit and review should be performed with some routine.

## CONSULTANT CLOSING REMARKS & RFP BINDING SIGNATURE REQUIRED

We sincerely appreciate the opportunity to show the Mansfield City School District the level of service and experience our agency can provide. We have a history with the District, and we hope that our past service will also be a reference to how we treat this trusted role as a consultant.

We work nearly exclusively with Public Schools in Ohio, which gives us a very broad experience and expertise. We understand the balance of fiscal responsibility and the ability to attract and retain the quality staff your communities not only expect, but demand.

Given the opportunity, this agency will go above and beyond the comprehensive services requested and presented within this RFP. We will meet and exceed the current contract requirements, and we think you will see a difference in the way we interact with your District and your members. The challenges you face are changing daily, and we believe that our experience in public education will prove of great value to you immediately and in the long-term.

In the end, we share the same mission. Everything we help you accomplish financially allows you to expand the support and programming that you provide to those you serve. We are always aware of this mission and consider ourselves to be a partner towards the same goal. We look forward to any further discussion about our RFP Response, or the future direction of the Mansfield City School District.

*Thank you sincerely for the Opportunity and Consideration.*

K. Joseph Grady

Joe Grady, President
614-581-7242

# Appendix List of Exhibits

- Broker Agreement Proposal Exhibit
- Price Proposal Addendum-A Exhibit
- RFP as Issued by District
  for Reference & Binding Purposes
- Mineral ThinkHR Exhibit
- Existing Consultant Contract Exhibit

# APPENDIX ITEM

## CONSULTING & BROKERAGE SERVICES AGREEMENT

This agreement is made for the 20-Month period September 1, 2025 through June 30, 2027 upon the recommendation of the Mansfield City School's Insurance Committee. This agreement is approved and between the Board of Education of the Mansfield City School District (the "District") with primary place of business located at 856 West Cook Road, Mansfield, Ohio 44907; and Grady Enterprises, Inc. (the "Consultant" and/or "Grady") with primary place of business located at 515 East Mound Street, Columbus, Ohio, 43215. Grady Enterprises may also be known as (and doing business as) Grady Benefits.

In consideration of mutual covenants herein contained, both parties hereto agree as their interest may appear.

### Appointment of Consultant

The District agrees to appoint Grady Enterprises, Inc. as Consultant of Record for the Employee Benefits Programs and related services. Grady Enterprises, Inc. will represent and be obligated to generally perform for the District those services contained in the section described herein as **"Outline of Services".**

### General Obligation

Grady Enterprises, Inc. shall provide consulting services that will enable the District to maintain, negotiate and service the benefit programs available to district employees and their families.

### General Understanding

This contract in no way enables Grady Enterprises, Inc. to make decisions on behalf of the District and does not permit or advocate fiduciary duties or responsibilities.

### General Scope of Services

This contract pertains specifically to the following Benefits: Medical, Prescription Drug Plans, and Stop-Loss Coverage. All other lines of coverage may be encompassed within scope of services by assigning Grady Enterprises as Agent of Record. District may also exclude some lines of coverage from the contracted Scope of Services under Amendment.

## Outline of Services

The ongoing services provided to the District will include the following services pertaining to and involved with managing a self-funded insurance program.

- Review of Summary Plan Document (SPD)
- Review of Administrative Service Agreement (ASA)
- Review of Specific Stop Loss Agreement
- Review of Aggregate Stop Loss Agreement (Excess Loss)
- Monthly Evaluation of Claims Data
- Monthly Accounting of Funding to Claims Ratio
- Monthly Analysis of Expended Administrative Fees
- Review of Benefit Certificate
- Quarterly Claims Analysis with Carrier
- Attendance at Insurance Committee Meetings
- Preparation of Request for Proposal (RFP)
- Plan Design Analysis and Cost Containment Recommendations
- Comparison of Funding Alternatives
- Plan Design Savings from Deviation in Benefits
- Provider Discount Analysis
- Prescription Drug Analysis
- Financial and Funding Analysis
- Enrollment in Insurer System Access for Employer
- Monitor Provider Negotiations with Carrier
- Assistance for Individual Claims Issues, Disputes and Appeals
- Coordinate Actuarial Services for ORC 9.833 Compliance (audit fees not included).
- Available as Requested by Board of Education for Reporting
- Report on National and Local Trends, Legislation and Reforms
- Renewal Analysis for Medical, Prescription and Dental
- Advise and Educate on any other Product or Strategy
- Coordinate Wellness Programming Data Integration as Available
- Provide Materials and Data as Requested for Purpose of Union Negotiations
- Coordinate Dependent Audits (audit fees not included).
- Grady Enterprises does not provide direct legal counsel. Please seek legal advisement on matter of law.
    - Provide assistance in compliance and adherence to “Best Practices” mandates (Ohio Department of Administrative Services OAC 123-6).
    - Provide assistance in compliance and adherence to COBRA, HIPAA, ERISA and other regulations related to insurance.
    - Provide assistance in compliance and adherence to Affordable Care Act Requirements (tracking and reporting service fees not included).
- Any Additional Services not listed above as determined to be within the general scope of work as above.

### Compensation

The consulting fee represents agreed compensation for the **Medica**l, **Prescription, Stop-Loss, Disease Management Programs, Dental and Vision Benefit Plans**. Grady Enterprises is eligible to participate in additional compensation programs that are offered by insurance providers indirectly. Grady Enterprises agrees to assist with additional disclosure requests through 5500 Forms from insurers as confirmation of all compensation.

### Base Annual Retained Service Fee

Term and Fee as Approved by the Board of Education of the under the Pricing Attachment-A.

### Change in Scope or Termination of this Agreement

This agreement will become effective at such time that it is signed and instituted by both parties and approved by the Board of Education of the District. This agreement can be altered by either party with 60-days written notice as Legislative Reforms may amend scope of work or other changes are necessary.

## District

_____ _____

(Name and Title) (Date)

## Grady Enterprises, Inc..

_____ _____

(Name and Title) (Date)

*The pricing is included as an Addendum to the Agreement so that changes can be made by attachment without affecting the core agreement.*

## APPENDIX ITEM

Addendum-A to Consulting and Brokerage Services Agreement

### Mansfield City Schools

Contract Terms: See Contract and Agreement for Consulting and Brokerage Services
Contract Start Date: September 1, 2025
Contract End Date: June 30, 2027
Renewability Periods: Includes 12-Month Renewability Option July 1, 2027 – June 30, 2028
Contracted Lines of Coverage: Medical, Prescription, Stop-Loss (Health Plan Related Benefits)

**Contract Fee Proposal:**

**10-Month Period September 1, 2025 through June 30, 2026**

- **$9750 Per Month (Breakdown of this fee below)**
  - **$7500 Per Month is Fee to Grady Benefits**
  - **$1500 Per Month is Fee to PharmAssist**
  - **$750 Per Month is Fee to Parsons Actuarial**

**12-Month Period July 1, 2026 through June 30, 2027**

- **$8250 Per Month (Breakdown of this fee below)**
  - **$6250 Per Month is Fee to Grady Benefits**
  - **$1250 Per Month is Fee to PharmAssist**
  - **$700 Per Month is Fee to Parsons Actuarial**

**12-Month Option Renewable Period July 1, 2027 through June 30, 2028**

- **$9250 Per Month (Breakdown of this fee below)**
  - **$7000 Per Month is Fee to Grady Benefits**
  - **$1500 Per Month is Fee to PharmAssist**
  - **$750 Per Month is Fee to Parsons Actuarial**

**Ancillary Contracts**

- **Dental | Vision | Group Life | EAP | Worksite Voluntary Products and any other benefit or services offered will continue with the currently existing compensation model. This amount (if any) will be discovered and presented to the District as part of compensation disclosures.**

**District Recommended Options Included Above (See RFP Response Item 9 for Detail)**

- Pharmacy Consulting Specialist | Includes Core Services to 10-hours per Month with 5-Hours Project allocation. Does not include cost of mail and postage for any member correspondence (if needed).
- Actuarial Services |(includes ORC 9.833 Services and Ongoing Services Schedule)
- Grady Benefits will invoice and remit payment for Pharmacy & Actuarial Services.

**General Terms:**

- Contract Period Maximum: 34-Months Maximum.
- Contract Period Minimum: 10- Month Minimum
    - Contract Termination in the first 10-Months requires 10-Month Notice and payment for 10-Month Contracted Annualized Amount Total.
    - Contract Termination after the initial 10-Months requires 120-Day Notice and completed payment of monthly fees through the end date.
- The contract period is designed to allow District to get to a Fiscal Year Agreement Cycle. The first 10-Month term will end June 30th and then continue with 12-Month agreements on Fiscal Calendar Year.
- Grady Benefits may update or change the Pharmacy and Actuarial Services Provider as needed. Fee for Pharmacy and Actuarial Services are subject to changes and Grady Benefits will notify District of any changes with 90-Days Notice.
- It is noted that indirect compensation can apply and disclosure is required wherever Grady Benefits may be eligible and receive such compensation. Any indirect compensation is legally subject to disclosure requests as agreed.

**Other General Terms:**

Direct Fee for Service Contract for Insurance Consulting Services. Grady and District agree to terms of service on applicable lines of coverage within the scope of services. Compensation disclosures may be provided on each line of coverage offered as an employee benefit.

Grady and District generally agree that other lines of coverage may or may not be within the scope of the services descriptions. In such cases, it will be assumed the service is included under this agreement unless District expressly excludes or amends the contract as such. Compensation (if any) for additional services or lines of coverage will be addressed at the time programming is being offered, reviewed or considered by the District or determined to be within the scope of services offered under contract. Where services are outside the Scope of Services for Contract, Grady Benefits agrees to Standard Compensation only after it has been disclosed and approved by the District.

When services are required to be performed by a Third Party; Grady agrees to assist and facilitate services and vendor contracting. However, additional costs of those services may not be included within the fee proposed by Grady. Current known exempt services: ACA Reporting, and Employee Benefit Enrollment Platform Services.

Fees for these services are generally estimated as a cost for the District:

- ACA Reporting: $1.00 Per Employee Per Month.
    - Service performed and filed by ACAPrime. Fee can be direct contracted with ACAPrime, or funded as $1.00 PEPM included in Consultant Fee. $1.00 PEPM covers the cost of Annual Setup Fee, Annual Maintenance Fee, Costs of Printing & Mailing of Required Forms.

- Benefit Enrollment Platform: $0.00 to $5.00 Per Employee Per Month
    - Online enrollment platforms are available in a wide range of costs and services. Grady will work with District to find cost-effective options that meet the requirements and needs of the District.

## APPENDIX ITEM

### RFP as Issued by District

As noted in RFP Response, please accept our response as agreement to terms and conditions described within the District RFP as Issued. The following specified sections of the RFP were understood to be District expectations and are included under Appendix A within our response for reference and binding purposes only. Includes Sections: **Introduction | Confidentiality | Benefits Overview |Services |Proposal Instructions | General Information**

Mansfield City Schools

MANSFIELD CITY SCHOOLS
856 W COOK ROAD
MANSFIELD, OH 44907

## Request For Proposal for Health Benefit Consulting Services

### INTRODUCTION

The Mansfield City School District (MCSD) serves 2,900 students in grades PreK-12. The district employs over 600 people and sponsors a self-funded group health plan. The Mansfield City Schools offers a medical, prescription drug, dental, and vision plan. All three plans require an employee contribution. The medical plan offered is a High Deductible Health Plan, but a few employees are grandfathered to contribute to a Preferred Provider Organization (PPO) plan. All the plans are self-insured with a $100,000 specific stop loss through MMO. The claims and stop loss vendor for medical and dental is Medical Mutual of Ohio. Prescription drug coverage falls under the MMO agreement with Express Scripts. Vision and Life are managed by MetLife.

All employees of the district (certificated, non-certificated, and administrative staff) are eligible to participate in the plan. The district has 397 eligible employees participating in the HDHP plan, with 132 single contracts and 265 family contracts. The district has 16 eligible employees participating in the PPO plan, with 5 single contracts and 11 family contracts. Due to a recent RIF, there will be approximately 70 fewer employees on the insurance plan in August of 2025. The district has 15 single employees and 15 employees and their spouses participating in a Medical Expense Reimbursement Plan (MERP). The district reimburses $6,000.00/year for the employee and $12,000.00/year for the employee and spouse.

It is critical to understand that the district agrees to fund a fixed amount per employee per month, and any change in the health insurance plan must maintain benefits within those fixed amounts.

| | Family | Single |
|---|---|---|
| HDHP Deductible | 5,000.00/year | 3,300.00/year |
| HDHP Employee Share | 162.00/month | 81.00/month |
| PPO Deductible | 3,000.00/year | 1,500.00/year |
| PPO Employee Share | 463.76/month | 191.42/month |
| H.S.A. Employer Share | 2600.00/year | 1,600.00/year |

## CONFIDENTIALITY

As a condition of your receipt of this request, you agree not to disclose to anyone, other than partners and employees directly connected with responding to this request, any information concerning this request or any information obtained in subsequent communications with MCSD, except to the extent such information is otherwise publicly available. No public announcements or other references to this request may be made without the prior written consent of MCSD.

## BENEFITS OVERVIEW

The Mansfield City School District's plan year is January 1st through December 31st of each year. The district offers two plans. Below is an outline of the current MCSD plan offerings.

| Coverage Type | Renewal Date | Carrier/Admin | Enrollment | Funding type |
|---|---|---|---|---|
| Medical-HDHP | 1/1/2025 | MMO | 397 | Self-funded |
| Medical-PPO | 1/1/2025 | MMO | 16 | Self-funded |
| Pharmacy | 1/1/2025 | Express Scripts | 413 | Self-funded |
| Stop Loss | 1/1/2025 | MMO | Specific Stop-Loss: $100,000 | Self-funded |
| Dental | 1/1/2025 | MMO | 432 | Self-funded |
| Vision | 1/1/2025 | MetLife | 434 | Employee/Employer Funded |
| Life (w/ AD&D) | 1/1/2025 | MetLife | 528 | Employer Funded |
| Voluntary Life | 1/1/2025 | MetLife | | Employee Funded |
| Voluntary Products: | 1/1/2025 | MetLife | | Employee Funded |
| H.S.A. | 1/1/2025 | Mechanics Bank | | Employee/Employer Funded |

## SERVICES

MCSD seeks the following services (at a minimum) in conjunction with this request:

- Strategic plan
- Market review and cost/network analysis of multiple insurance carriers
- Review of various carrier agreements
- Recommendations of benefit plan design modifications, including possible Consortium membership options
- Claims resolution, assistance with benefit issues, and TPA administration options
- Evaluation and reporting of plan performance
- Recommendations to reduce claims experience and premiums
- Evaluation and recommendations for our stop-loss coverage
- Evaluation and recommendations for our Prescription Drug program
- Consultation with the MCSD Treasurer's department as needed
- Compliance advice regarding federal and state laws, and other requirements
- Open enrollment & communications support
- Wellness program support

## PRESENTATION EXPECTATIONS

Each brokerage firm should be prepared to address the following during its presentation.

1. Brief overview of your firm.
2. Structure, roles, and expertise of the team that would service MCSD's account.
3. Describe the core services typically provided to your clients, and indicate services some clients need outside of that core scope.
4. Describe some of the processes, tools, and resources your firm would use in the analysis of potential solutions and prospective vendors for MCSD.
5. What trends do you see in employee benefits?
6. How is your firm becoming an expert and helping your clients with these trends?
7. What differentiates your firm from your competition?
8. What should we expect as customers over the next 12 months?
9. Description of proposed compensation structure for these services
10. Experience with self-funded health insurance plans
11. Experience with Ohio public school district health insurance plans
12. Experience with negotiated agreements and multiple union groups as part of a District Insurance Committee
13. Experience with Employee Care Medical Facilities

## PROPOSAL INSTRUCTIONS

Proposals in response to this RFP will be received by the Mansfield City School District until **Friday, June 20, 2025**. Respondents selected as finalists will be invited to meet with the MCSD Insurance Committee. Proposals may be sent electronically or via mail to: Tammy Hamilla, Treasurer, Mansfield City Schools, 856 W Cook Road, Mansfield, OH 44907, hamilla.tammy@mansfieldschools.org.

## GENERAL INFORMATION

MCSD will not discriminate in the purchase of goods and services based on race, color, creed, sex, handicap, or national origin. Verbal quotations or quotations received after the closing date will not be accepted. MCSD reserves the right to reject any bids, to waive technicalities or informalities and to accept any bid deemed to be in the best interest of the MCSD. The district reserves the right to reject individually or collectively all respondents and accept responses in full or in part. All service contracts shall comply with applicable Federal, State, and Local statutes, rules, and regulations. The successful Respondent shall not assign, transfer, convey, sublet, or otherwise dispose of any award or any or all of its rights, title or interest therein, without prior written consent from the district. Such consent by the district shall not relieve the assignor of liability in the event of default by the assignee. Respondents shall indemnify, hold harmless, and exempt the district, its officers, agents, servants, and employees from and against any such suits, actions, legal proceedings, claims, demands, damages, costs, expenses, attorney fees and any other costs or fees incident to any work done as a result of the request for proposal and arising out of a willful or negligent act or omission of the successful Respondent, its officers, agents, servants and employees.

We appreciate your interest in partnering with the Mansfield City School District and look forward to speaking with you soon.

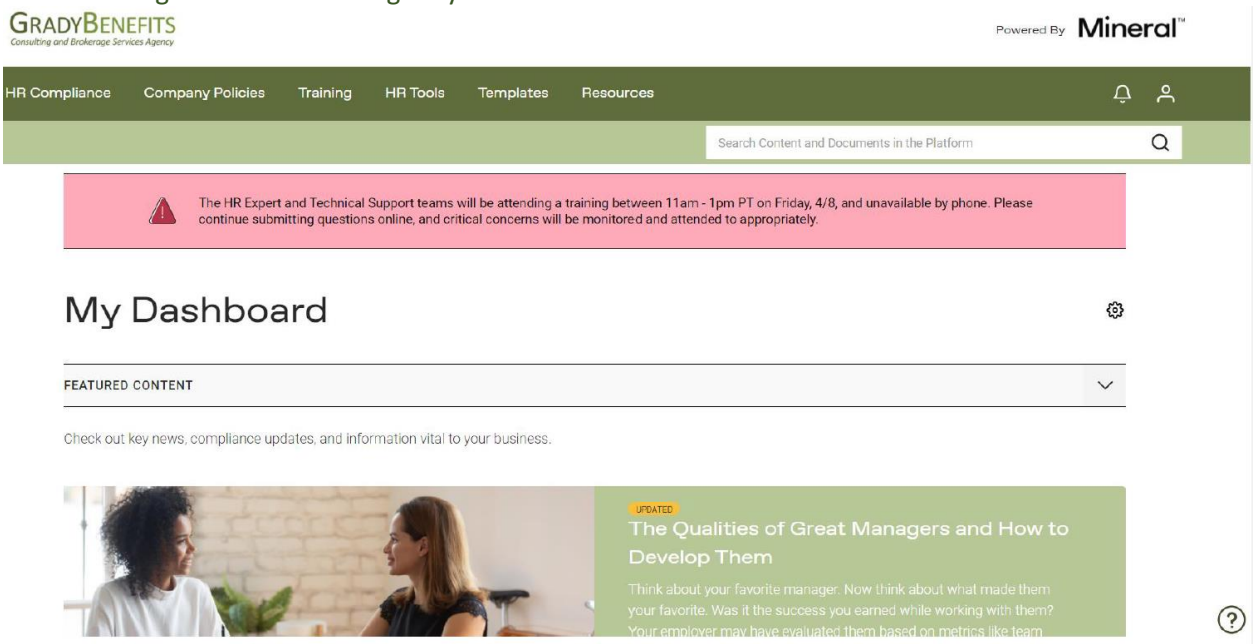
**Tammy Hamilla, Treasurer**
**hamilla.tammy@mansfieldschools.org**
**(419) 525-6400 ext. 1005**

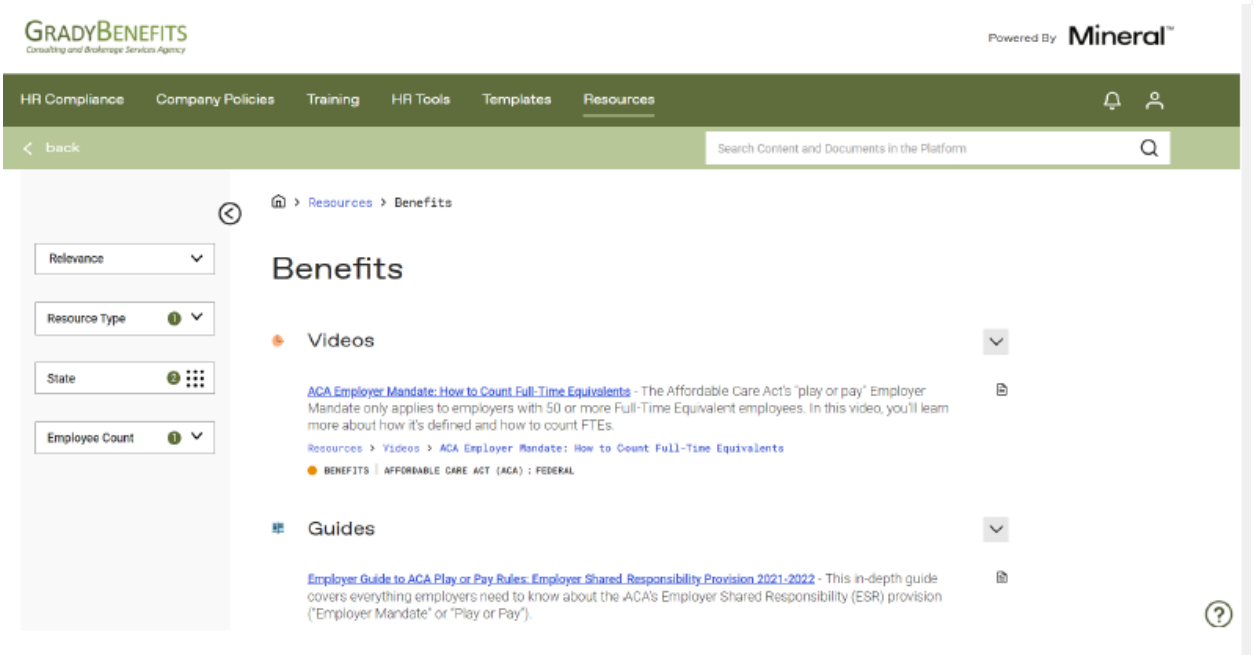
## APPENDIX ITEM

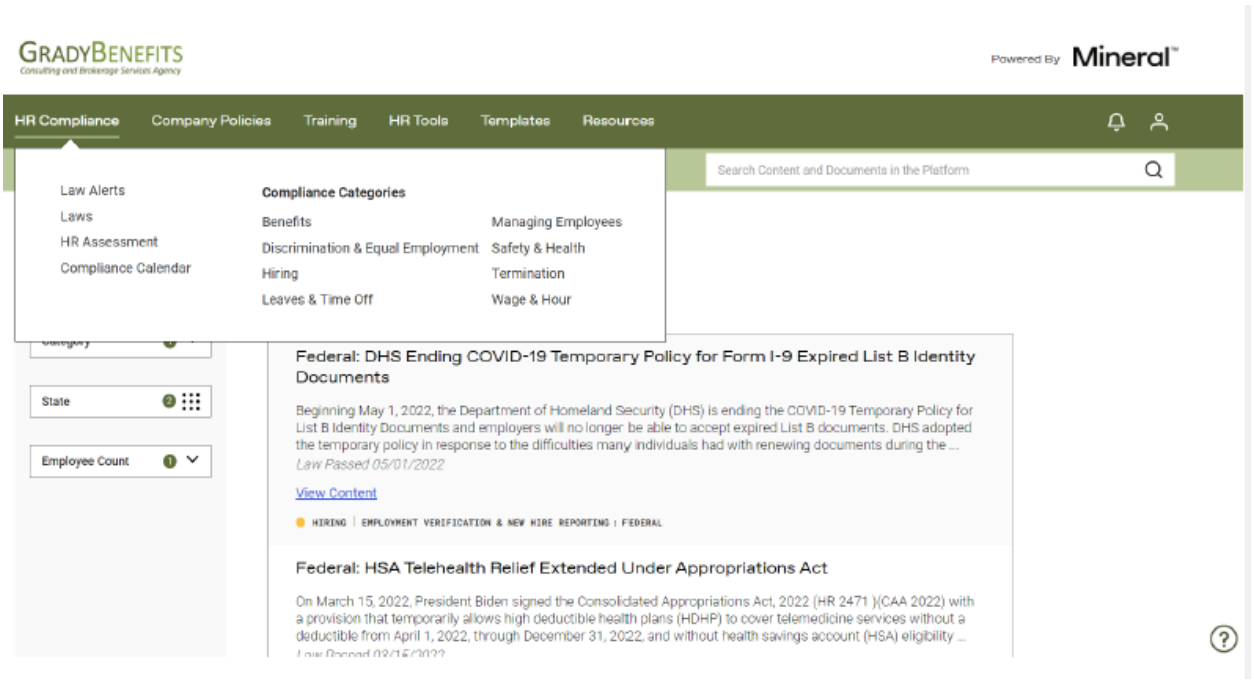
### APPENDIX – ThinkHR / Mineral Portal

Our groups also receive access to Mineral (ThinkHR) Portal for additional resources on Notices, Employee Handbooks, and other policy templates that can be used as needed for Board Policy (and to meet legal requirements on the plan).

The following screenshots will give you an idea of the resources we offer to Benefits & HR.

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Consulting and Brokerage Services Agency
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HR Compliance
Company Policies
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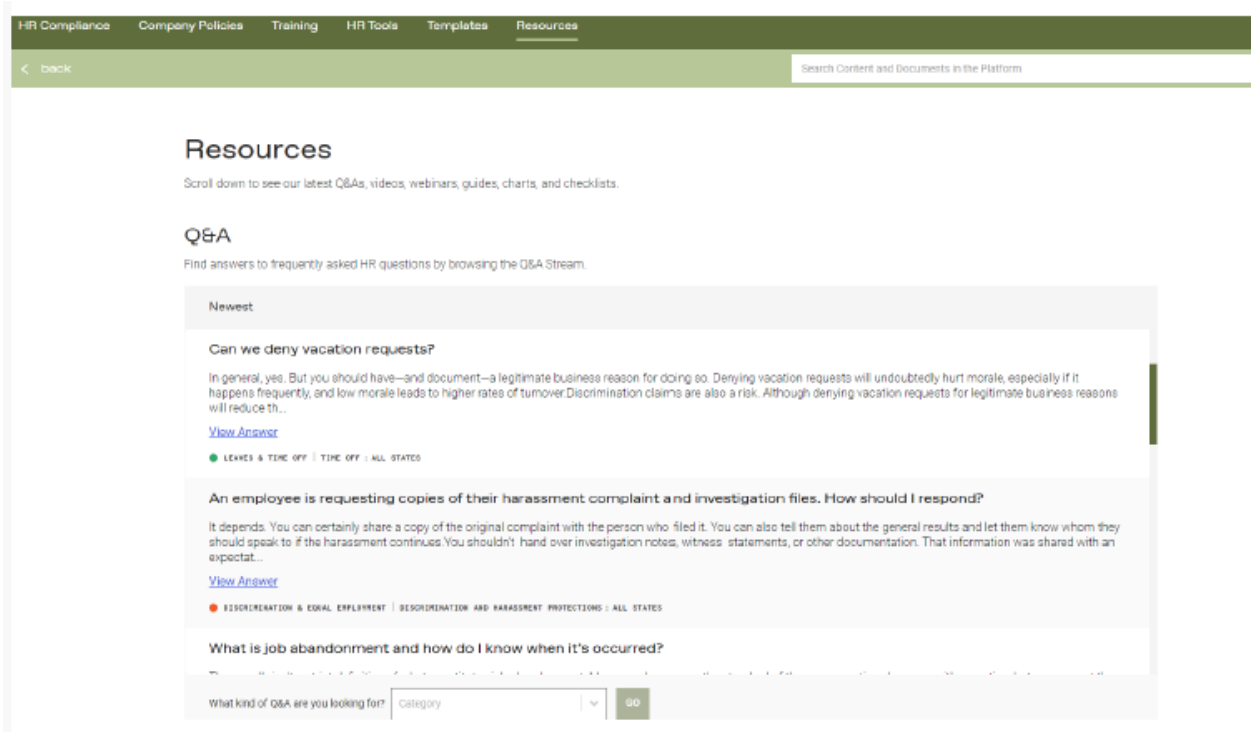
HR Assessment
Compliance Calendar
Compliance Categories
Benefits
Discrimination & Equal Employment
Hiring
Leaves & Time Off
Managing Employees
Safety & Health
Termination
Wage & Hour
State
Employee Count
Federal: DHS Ending COVID-19 Temporary Policy for Form I-9 Expired List B Identity Documents
Beginning May 1, 2022, the Department of Homeland Security (DHS) is ending the COVID-19 Temporary Policy for List B Identity Documents and employers will no longer be able to accept expired List B documents. DHS adopted the temporary policy in response to the difficulties many individuals had with renewing documents during the ...
Law Passed 05/01/2022
View Content
HIRING | EMPLOYMENT VERIFICATION & NEW HIRE REPORTING : FEDERAL
Federal: HSA Telehealth Relief Extended Under Appropriations Act
On March 15, 2022, President Biden signed the Consolidated Appropriations Act, 2022 (HR 2471 )(CAA 2022) with a provision that temporarily allows high deductible health plans (HDHP) to cover telemedicine services without a deductible from April 1, 2022, through December 31, 2022, and without health savings account (HSA) eligibility ...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Search Content and Documents in the Platform
Resources
Scroll down to see our latest Q&As, videos, webinars, guides, charts, and checklists.
Q&A
Find answers to frequently asked HR questions by browsing the Q&A Stream.
Newest
Can we deny vacation requests?
In general, yes. But you should have—and document—a legitimate business reason for doing so. Denying vacation requests will undoubtedly hurt morale, especially if it happens frequently, and low morale leads to higher rates of turnover.Discrimination claims are also a risk. Although denying vacation requests for legitimate business reasons will reduce th...
View Answer
LEAVES & TIME OFF | TIME OFF : ALL STATES
An employee is requesting copies of their harassment complaint and investigation files. How should I respond?
It depends. You can certainly share a copy of the original complaint with the person who filed it. You can also tell them about the general results and let them know whom they should speak to if the harassment continues.You shouldn't hand over investigation notes, witness statements, or other documentation. That information was shared with an expectat...
View Answer
DISCRIMINATION & EQUAL EMPLOYMENT | DISCRIMINATION AND HARASSMENT PROTECTIONS : ALL STATES
What is job abandonment and how do I know when it's occurred?
What kind of Q&A are you looking for?
Category
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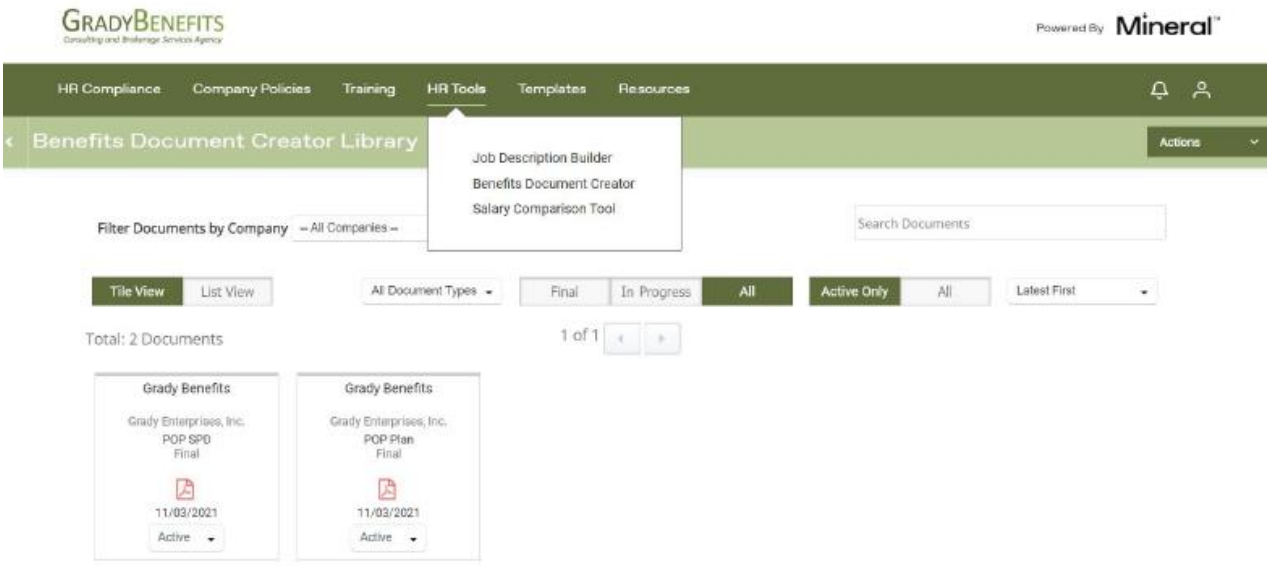
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Job Description Builder
Benefits Document Creator
Salary Comparison Tool
Filter Documents by Company
-- All Companies --
Search Documents
Tile View
List View
All Document Types
Final
In Progress
All
Active Only
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Latest First
Total: 2 Documents
1 of 1
Grady Benefits
Grady Enterprises, Inc.
POP SPD
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Grady Benefits
Grady Enterprises, Inc.
POP Plan
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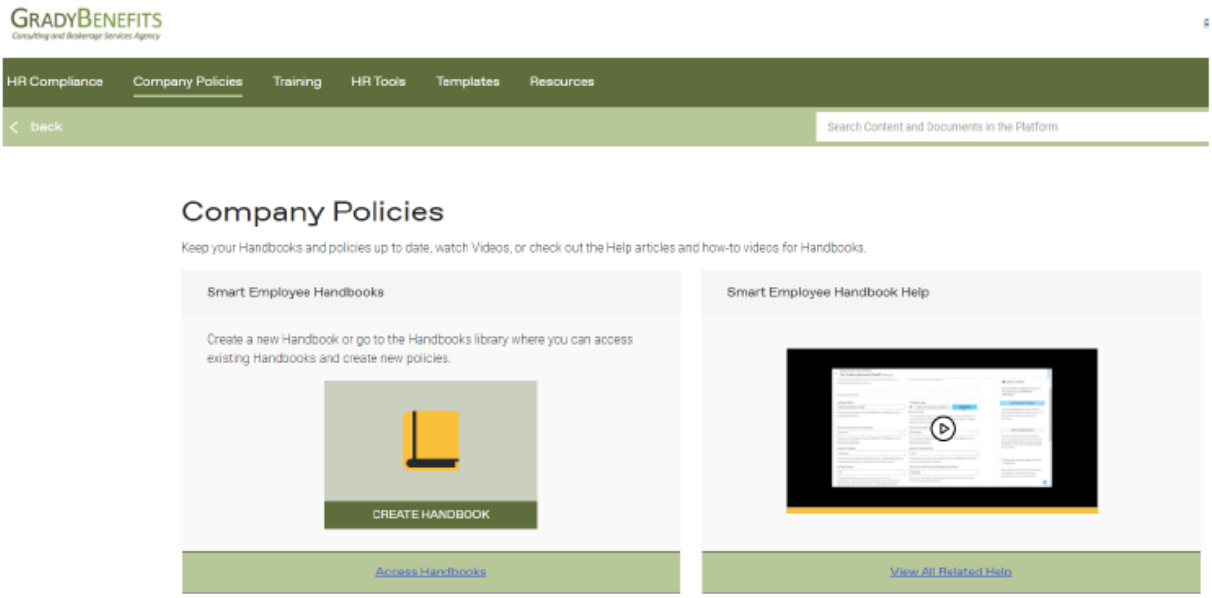
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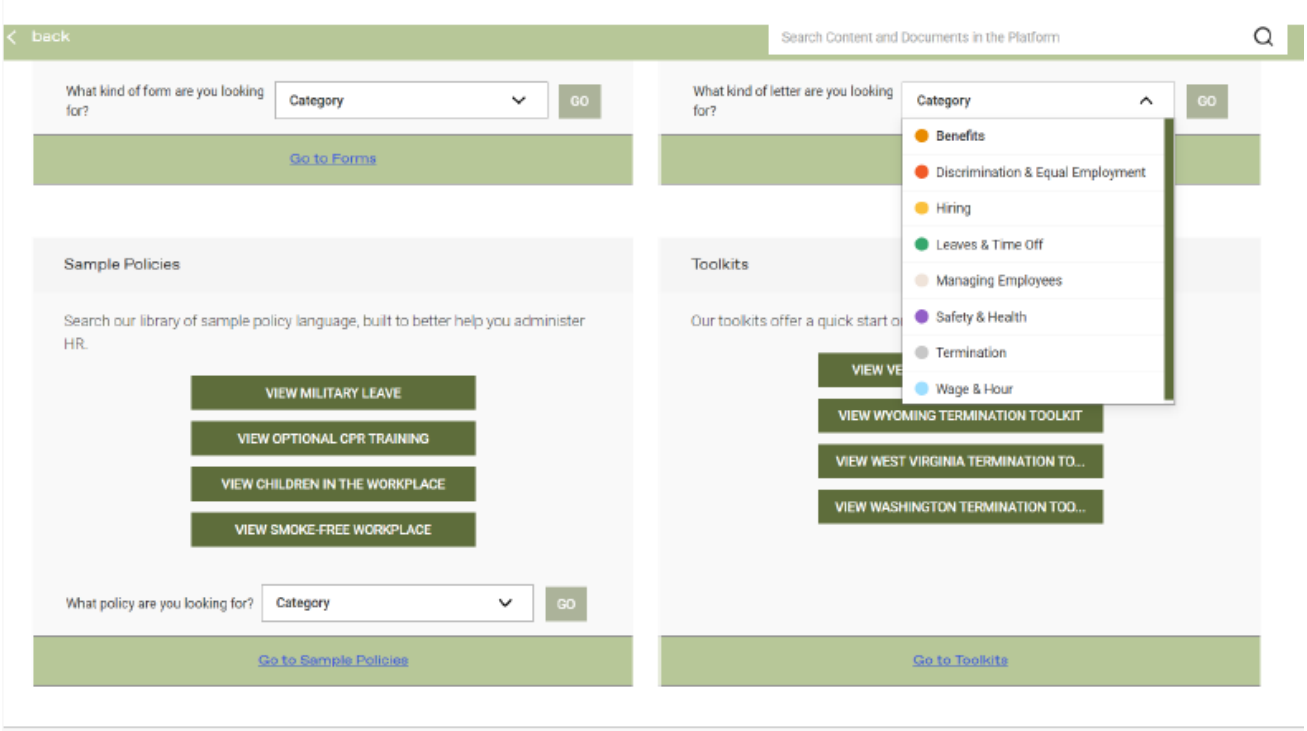
Keep your Handbooks and policies up to date, watch Videos, or check out the Help articles and how-to videos for Handbooks.
Smart Employee Handbooks
Create a new Handbook or go to the Handbooks library where you can access existing Handbooks and create new policies.
CREATE HANDBOOK
Access Handbooks
Smart Employee Handbook Help
View All Related Help
Top Questions
Below are some of the most frequently asked questions and answers related to Smart Employee Handbooks and best practices for creating and maintaining compliant company policies.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Search Content and Documents in the Platform
What kind of form are you looking for?
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Go to Forms
What kind of letter are you looking for?
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Benefits
Discrimination & Equal Employment
Hiring
Leaves & Time Off
Managing Employees
Safety & Health
Termination
Wage & Hour
Sample Policies
Search our library of sample policy language, built to better help you administer HR.
VIEW MILITARY LEAVE
VIEW OPTIONAL CPR TRAINING
VIEW CHILDREN IN THE WORKPLACE
VIEW SMOKE-FREE WORKPLACE
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Toolkits
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VIEW WEST VIRGINIA TERMINATION TO...
VIEW WASHINGTON TERMINATION TOO...
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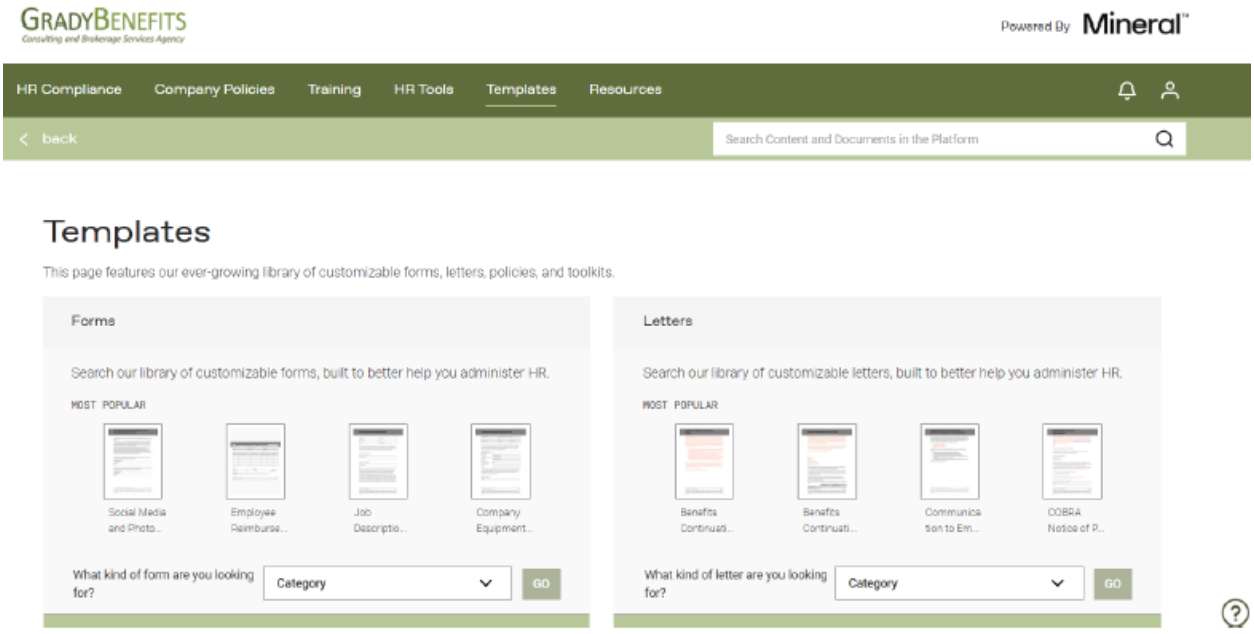
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Search Content and Documents in the Platform
Templates
This page features our ever-growing library of customizable forms, letters, policies, and toolkits.
Forms
Search our library of customizable forms, built to better help you administer HR.
MOST POPULAR
Social Media and Photo...
Employee Reimburse...
Job Descriptio...
Company Equipment...
What kind of form are you looking for?
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Letters
Search our library of customizable letters, built to better help you administer HR.
MOST POPULAR
Benefits Continuati...
Benefits Continuati...
Communica tion to Em...
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What kind of letter are you looking for?
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## APPENDIX ITEM

**APPENDIX – Exisitng Benefit Consulting Agreement Reference**

The existing agreement between District and Consultant is not provided as part of the RFP Request. It was also unavailable online in available board documents.

Grady Benefits has responded to the District RFP assuming that the RFP Scope of Services are similar to the existing services being provided (under the current agreement and compensation structure). We can structure our agreement in the same language to facilitate approval through Board and Legal Counsel Review.

**If no agreement currently exists, we can provide sample Contracts and Business Associates Agreements. We are also flexible to use contracts from your legal counsel (that have already been approved by you and your attorneys).**

***RFP Response Concluded.***

***Thank you for your time and consideration.***