REQUEST FOR PROPOSAL

Fully Insured Medical & Pharmacy Benefits

RFP 25-013

Arkansas Tech University
Russellville Arkansas

Advisors

Tom Kane, Executive Vice President - Life & Health– tkane@stephens.com

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501-377-2093

Stephens Insurance, LLC
111 Center Street
Little Rock, AR 72201

July 18, 2025

Table of Contents

I. OVERVIEW – Who are we?

Founded in 1909, Arkansas Tech University ("ATU") is a public, comprehensive, regional University with a rich history, maintaining regional accreditation from the Higher Learning Commission (HLC) and classification as a Southern Regional Education Board (SREB) level III institution. ATU was ranked the No. 1 regional public university in Arkansas by U.S. News and World Report in 2021-22 and 2022-23 and CollegeNET recognizes ATU as the No. 1 institution in Arkansas on its Social Mobility Index. Since 2019, Arkansas Tech has been the host institution for the prestigious Arkansas Governor's School.

ATU offers instruction in locations across the Arkansas River Valley. These campuses give students complete access to higher education. With programs ranging from a certificate of proficiency through a doctorate, they can leverage career goals without leaving the River Valley.

The 500-acre Russellville campus, located in the scenic Arkansas River Valley between the Ozark and Ouachita Mountains, is just one hour from the capital city of Little Rock. Russellville features a charming blend of historic and modern architecture as well as the recreational opportunities provided by Lake Dardanelle and several state parks. The Russellville campus offers associate's degrees, bachelor's degrees and graduate degrees taught in modern facilities with top-tier technology.

The ATU-Ozark Campus offers dozens of certificates of proficiency, technical certificates and associate's degrees —students will be ready to begin a rewarding career in their industry quickly. Students are able to enhance their careers at multiple stages with stackable credentials in partnership with ATU - Russellville. That means a student can start with a certificate and work all the way through to a graduate degree without leaving the Arkansas Tech University system.

The Arkansas Tech Career Center ("ATCC") is one of the largest secondary career and technical centers in Arkansas, serving nearly 1,000 high school students across the Russellville campus and our satellite campuses in Ozark and Paris. ATCC programs are designed to provide high-quality career and technical education that equips students with the skills needed for high-demand, high-skill jobs, helping to build a well-prepared workforce that drives economic growth in the River Valley Region.

ATU has approximately 780 benefit eligible employees located on three campuses – Russellville, Ozark and the Arkansas Tech Career Center (ATCC). ATU also provides benefits to pre-65 Retirees (25) and post-65 Retirees (27).

ATU currently offers the following benefit programs:

- Medical
- Dental
- Vision
- Basic and Voluntary Group Life
- Voluntary Short Term and Long Term Disability
- Critical Care with Cancer
- Accident
- Section 125 (HSA and FSA)
- Hospital Care

B. The Exhibit Section includes:
   - Exhibit A – Benefit Eligible Employees/Retirees
   - Exhibit B – Current Benefit Designs
   - Exhibit C – 2026 Renewal Information
   - Exhibit D – Reporting – Claims and High Claimant
   - Exhibit E – Census to be sent securely as a separate attachment

C. ATU currently offers an HSA and PPO plan to all full-time employees. ATU's premium contribution is structured, based on annual income. ATU offers Pre-65 Retirees the option to stay on the plan that they are on at the time of their termination of full-time employment if they are 60+ years old and have 10 years of service with ATU. Retirees will age off the plan at the end of the month prior to their 65th birthday. ATU also has a grandfathered $950 PPO Retiree plan that currently has 12 members and no additional retirees will be added.

D. The current prescription plan for the PPO is a 4-tier copay with a mail-order option.

E. ATU uses a Benefit Administration System (PlanSource) for benefit eligibility. This service is provided at no cost to ATU by Stephens Insurance, LLC. Please indicate if you will include a subsidy to help support Benefit Administration.

II. REQUEST FOR PROPOSAL

ATU respectfully requests proposals for fully insured medical and pharmacy benefits effective January 1, 2026.

- Fully Insured Medical Benefits and Prescription Drug coverage including
  - Utilization Management
  - Large Case Management
  - Disease Management
  - Member Portal Access to Benefits
  - Wellness and Healthy Lifestyle programs

The outcome from this RFP process is to select the most likeminded Health Benefit partner that will support and enhance our objectives to:

- Implement a program that will help our employees become healthier
- Control costs
- Educate employees on how to best utilize benefits
- Make utilization of the plan accessible
- Promote wellness and lifestyle programs

Each organization is requested to duplicate the current benefit structure as closely as possible.
Additional alternate plan designs are invited including alternates for Pre and Post 65 Retirees. ATU will consider other prescription plan designs such as special services for drug utilization management, prior authorization, specialty drug 4th tiers, and other mail order drug benefit options. All benefit alternatives will be seriously considered to minimize the financial burden of expenses to the ATU and participants**.**

Other alternates are invited as long as they are clearly described and include a Summary of Coverage as distributed to participants.

Please include your organizations Programs that are designed to promote healthy living and wellness and cost, if any, associated with each.

PLEASE NOTE: ANY CONFIDENTIAL, PROPRIETARY, COPYRIGHTED OR FINANCIAL MATERIAL SUBMITTED BY RESPONDENTS MUST BE MARKED AS SUCH AND SUBMITTED UNDER SEPARATE COVER. FAILURE TO MARK WILL RESULT IN THE RELEASE OF RECORDS REQUESTED UNDER THE FOIA. ALL SUBMITTALS BY PROPOSERS WILL BE AVAILABLE FOR REVIEW TO THE EXTENT PERMISSIBLE, PURSUANT TO THE ARKANSAS FREEDOM OF INFORMATION ACT 25-19-10-ET SEQ."

III. CONSULTANT, TIME TABLE OF SELECTION PROCESS AND DEADLINE

Stephens Insurance, LLC has been retained to provide consulting services for ATU. On your proposal, 1% commission should be added as compensation to Stephens Insurance, LLC. Stephens Insurance, LLC and ATU's Employee Benefit Insurance Committee (EBIC) will analyze all proposals.

QUESTIONS

Please address all questions regarding this request for proposal to:

Tyler Runnells Phone: 501-377-2093 E-mail: tyler.runnells@stephens.com	**OR**	Adam Ritchie Phone: 501-377-8415 E-mail: adam.ritchie@stephens.com

Direct all questions regarding the proposal to the above persons in writing, no later than August 1, 2025.

TIMETABLE OF SELECTION PROCESS

Activity	Completion Date
Release of RFP	July 28, 2025
Questions due from TPAs	August 4, 2025
Response to TPA questions due	August 9, 2025
Proposals due	August 25, 2025
Finalist presentations	TBD
Effective date	January 1, 2026

PROPOSAL DEADLINE

Stephens Insurance, LLC and ATU must receive an electronic copy of your proposal no later than August 25, 2025, at 4:00 p.m. ATU is to also receive an electronic copy (flash drive). This includes the completion of the following questionnaires and exhibits:

- General Information Questionnaire
- Medical Claims Processing Questionnaire
- Utilization Management Questionnaire
- Disease Management Questionnaire

Delivery of proposals:

You will be provided with a link to our secure and encrypted ShareFile site. Only your team, and the Stephens Insurance team will have access to each carrier response folder. We highly encourage and prefer that all responses are uploaded here in the current remote workplace environment. Hard copies of the proposal are not requested at this time.

If your company is unable to access ShareFile we will require a zip drive to be submitted with the required materials on it. Contact the individuals below for delivery instructions. Note your materials will be uploaded to ShareFile by the Stephens team should you require this option.

Submit to:

Stephens Insurance, LLC
Attention: Adam Ritchie
RFP 25-013
111 Center Street, Suite 100
Little Rock, AR 72201
Email: adam.ritchie@stephens.com

Arkansas Tech University Procurement Services
RFP 25-013
404 N El Paso Ave.
Russellville, AR 72801
Email: purchasing@atu.edu
Phone: (479) 968-0269

REVIEW OF PROPOSALS

ATU and/or Stephens Insurance, LLC reserves the right to:

- Reject any or all components of proposals.
- Cancel the entire RFP process.
- Remedy technical errors in the RFP.
- Negotiate with any, all or none of the respondents to the RFP.
- Solicit the best and final offers from all or some of the prospective vendors.
- Accept any or all components of the proposal as an "offer" without negotiation and issue notice to proceed.

PROVISIONS DEEMED INCLUDED IN THE PROPOSAL

Your organization may wish to propose an alternative to these specifications by expressly and specifically so stating in its proposal. Included are specific requirements in an attempt to evaluate all proposals on a uniform basis. If your organization feels that any of the provisions are unreasonable, contact Tyler Runnells and Stephens Insurance, LLC. Stephens Insurance, LLC will determine whether or not the provision should be amended.

MANDATORY PROVISIONS

Each proposal received by ATU shall automatically be deemed to include the Organization's agreement to the following provisions:

1. The proposal constitutes an offer by the Organization, which shall remain open and irrevocable, for 180 days from the deadline for submitting proposals as stated in Section III.
2. The organization consents to ATU and/or Stephens Insurance, LLC contacting and obtaining any information relevant to this RFP from the references and others identified by the Organization in its proposal.

IV. GENERAL INFORMATION QUESTIONNAIRE

1. Provide the full name of your organization, address, and telephone numbers. Also, provide a detailed summary of your Organization's structure, background, and experience in the healthcare industry. Describe the organization's resources and capabilities, including size, number of offices, locations, and number of employees.

2. Please provide a list of each company name and location for all services such as call centers, third-party vendor agreements and data storage, etc. that is conducted, warehoused or provided outside of the United States.

3. Describe any organizational structure/operational changes, which may occur within the next eighteen months.

4. Provide a list of five (5) client references for which you provide the services being requested, including clients that closely mirror the size and geographic location of ATU, including name and telephone number of a contact person as well as the number of employees and services in place at employer.

5. Provide a list of two (2) former clients that have recently terminated their services with you, not to include any terminated due to an acquisition. Include the name and telephone number of a contact person as well as the number of employees and services terminated.

6. Please provide an implementation plan and detail the timing of when the following will be available assuming your Organization is awarded the ATU account effective January 1, 2026.

    - Contracts or administrative agreements
    - Claims system loaded with the ATU benefit plans
    - Receipt and testing of eligibility files with ATU's Benefit Administration Vendor
    - Testing of interfaces with other vendors
    - Reporting requirements
    - Open enrollment planning
    - Employee communication
    - Employee access to benefits, claims, education, support information, and ID cards

7. Please describe the transition team that will work with ATU on implementation and transition issues.

8. Please indicate your willingness to work with the Benefit Administration vendor, PlanSource. Do you have existing clients that utilize PlanSource? Describe the procedure used to receive and transfer electronic data information feeds. Is there an additional cost for the EDI feed or setup?

V. MEDICAL CLAIMS PROCESSING QUESTIONNAIRE

GENERAL INFORMATION

1. Please provide the following information about the specific location from where claims administration services for medical will be provided (for the last three years):
   - address, telephone and fax numbers name and title of the individual responsible for the daily operations of this location
   - the number of clients served from this location
   - the number of members served from this location
   - the number of claims processors located in this location
   - the number of lives (employee and dependent) for which medical claims are processed in this location

2. Indicate the hours/days of operation (please be time zone specific) for the office that will service this account.

3. Describe your claims processing workflow from the time a claim is received in your office until the claim is resolved and/or payment is made.

4. Provide your definition of a claim.

CLAIM OFFICE PERFORMANCE—QUALITY AND ACCURACY

5. Describe the auditing program currently in place for ATU. Include information on the following:
   - Auditing procedures (both internal and external)
   - Definition of auditing categories
   - Frequency/percentage of production audited
   - Description of staff performing the audits
   - Communication of audit results (to processors and client)
   - The latest copy of your Organization's Statement of Standards for Attestation Engagement No. 16 (SSAE NO. 16) Report
   - A copy of your organization's Reporting on Controls at a Service Organization (SOC1.Type 2) Report

6. What are your standards for claims processing?
   - Payment accuracy (%)
   - Procedural accuracy (%)
   - Financial accuracy (%)
   - Turnaround time
   - Volume per day

7. What are your 2023 and 2024 results for claims processing?
   - Payment accuracy (%)
   - Procedural accuracy (%)
   - Financial accuracy (%)
   - Turnaround time
   - Volume per day

8. Provide your definition of claims turnaround.

9. Describe the procedures employed by the claims processors to review medical claims for compliance with benefits, to measure the reasonableness of charges and to determine the appropriateness of services. Are there separate groups of reviewers for network claims, appeals, etc.?

10. How does your system track alternate recipient information?

11. Please respond to the following regarding EOBs:
    - Provide a copy of your medical EOB and include a listing of all message codes and their associated message description.
    - Do you have the ability to include multiple message codes on each EOB to accurately communicate the resulting charge to the employee?
    - Are your EOBs printed and mailed in-house or off-site?
    - Will your system email notification to an employee when a claim has been processed?
    - Does the claims administration system automatically produce EOBs?
    - Does your organization have a standard EOB remarks table? If so, include a copy of this table.
    - Does the EOB show the amount of deductible that the employee has yet to satisfy?
    - Can the EOB be accessed through a member portal? Please provide information on how to access this information.

CLAIM SYSTEM & PROCEDURES

12. Identify all information that is integrated and online in your claim system with regard to:
    - UM decisions
    - Network procedures
    - Claims under case management

13. Describe the process of handling claim subrogation. Do you request the covered person or the covered person's guardian to execute a subrogation agreement? Please provide a copy of your standard agreement.

14. Describe the procedures for identifying and reviewing special medical cases such as medical necessity, experimental procedures, complex cases, etc.:
    - Pre-certification review
    - Concurrent review
    - Retrospective review
    - Outpatient review

- Second surgical opinion
- Catastrophic/large case management
- Short term case management
- Discharge planning
- High-risk pregnancy
- Pre-payment claim review
- Chiropractic/podiatric review
- Rehabilitation services

15. Are all claims accepted by electronic submission? For those that are not, how are they handled?

16. What are your requirements for submitting claim forms for in-network and out-of-network claims?

17. Describe your policies and procedures when a claim is received with incomplete information. What specific steps do you take to minimize employee involvement and inconvenience?
18. Describe your reporting capabilities, turnaround time, and any additional fees for reporting or ad hoc reports that may be requested.

19. Describe your experience in managing a smooth transition of a sizable block of business from another insurer.

20. Describe how your organization will negotiate discounts for claim costs associated with non-network providers. Is this process done in house or by a third party?

21. Describe your process for resolution of a mistaken or erroneous benefits payment.

22. Is subrogation recovery handled internally? If by an outside vendor, give the name of the vendor.

23. When is a subrogation claim turned over to an attorney? Who selects the attorney? Does ATU have the ability to designate the attorney who will pursue subrogation rights?
24. Describe your disaster recovery program concerning computer files, claim system, and loss of the facility. Include the back-up procedures in the event of a claim system shutdown.

SYSTEMS & PROCEDURES

25. How does your system accept enrollment information? Describe your procedures for the receipt of eligibility data including your preferred method and file layout for electronic file transfer. How are rejected transactions handled? What is the frequency and method of eligibility updates?

26. How is the confidentiality of eligibility information secured?

27. Describe your process for establishing and verifying dependent eligibility.

28. Describe your procedures for handling pended claims.

29. Describe the tracking mechanisms you follow for all communications requiring additional information.

CUSTOMER SERVICE

30. ATU requests an assigned primary administrative and service contact from your organization, other than the salesperson. Will dedicated claim processors and customer service representatives be assigned to this account? If so, how many? Please provide a brief resume of each individual.

31. Provide the following information about the specific location from which customer service will be provided: address, telephone, and fax numbers.

32. Indicate the hours of operation and days of the week (please be time zone specific) for the Customer Service office that will service this account.

33. Describe your provisions for "after hours" customer service.

34. Does your customer service unit have a toll-free number available for employees?

35. Do you have a dedicated customer service unit to respond to claim inquires or do the claims processors handle them?

36. ATU requests to have a service representative on campus one day per month. Please provide your willingness to provide this service. If costs are associated with this, please provide the cost.

37. Would the addition of this account require the hiring of new customer service personnel? Describe ratios/formula you utilize to determine at what point additional customer service personnel are required.

38. Provide the average length of service of your customer service representatives that would be servicing ATU. Additionally, provide the average length of service for those representatives that will be assigned to the ATU account.

39. Provide the following statistics and target service goals for the customer service unit that will service this account:

	2022 Actual	2023 Actual	2024 Actual	2025 Target
Average Answer Time				
Average Hold Time				
Abandonment Rate				
Average Talk Time				

40. Does your customer service system have call tracking capabilities? If so, please describe. Are specific issues tracked and reported in the aggregate so that issues can be resolved by both your organization and ATU?

41. As patterns are detected via call tracking, who has the responsibility for monitoring trends, for solving the identified problem, making the necessary changes and notifying the client?

42. Are customer service policies and procedures online and readily available to the customer service representative? Plan benefit information? Participant information? Provider information? Claims information? Telephone scripts?

43. Do customer service representatives have the ability to issue ID cards? Make address changes? Any other transactions?

44. Describe any features of your systems that in your opinion give your organization a competitive advantage concerning providing your clients with superior customer service.

45. Does your program include a silent monitoring program to measure quality?

46. Describe your customer service system reporting capabilities. Please provide samples of the reports that are regularly used to monitor performance. Can you produce reports by employer divisions?

PLAN DESIGN

47. Can your organization administer multiple plan design offerings, including Tiered Benefit Designs and Centers of Excellence that are not part of your network? If not, please provide a detailed description of those areas that you cannot administer and why.

REPORTING

48. Describe your standard offering of management reports by providing a brief description as well as a sample of each available report, including the frequency and available sorting options (sorted by age, gender, etc.).

49. Describe your ability to produce ad-hoc reports at the request of the client. What is the average time required to meet such requests? If additional costs are required, please include.

50. Please address the following items regarding data transfer:
    - Confirm your ability and willingness to provide reoccurring monthly files to Stephens Insurance and/or to other third parties, including a data analytics vendor and Benefit Administration Vendor. If additional cost, please provide cost information.
    - List any requirements you have before releasing the information. Specify the process including a timeline from request to delivery.
    - Include a sample eligibility and claims file specification including the list of available fields for both medical and pharmacy claims. If needed, will you add fields to the monthly claim files, which may not be included in your standard layout?

LIST OF SERVICES

51. Please provide a complete list of services that are included as part of your proposal.

52. Are the following online services available to members? Is there a mobile app available? List any additional online services offered.
    - Access to benefit summaries
    - Provider search
    - Prescription Drug Search
    - Claims status inquiry
    - Ability to e-mail customer service
    - Ability to order I.D. cards
    - Ability to review previous claims history
    - Ability to access third party medical and disease management information
    - Ability to access EOB
    - Wellness programs and tools

53. What employer on-line services do you offer? Would ATU have the ability to view eligibility or reports online? Would ATU have the ability to edit eligibility?

VI. UTILIZATION MANAGEMENT QUESTIONNAIRE

1. Please confirm that all UR services are performed internally. If any are subcontracted, please explain.

2. Describe your performance standards for the timeliness of reviews.

3. Does your organization have a full-time Medical Director or physician advisor on-site? Describe the Medical Director's major roles and responsibilities.

4. Describe the qualifications of nurse reviewers, case managers, and physician advisors.

5. Provide the ratio of registered nurses (full-time equivalents) per 1,000 covered lives.

6. For each of the following, indicate services provided for the fees quoted for in-network and out-of-network services and whether service is provided on-site or over the phone.

Description	Service Provided		Provision	
	In Network	Out of Network	On-site	By phone
Hospital pre-certification review				
Concurrent stay review				
Discharge planning				
Procedure specific second opinion (inpatient and outpatient)				
Large Case Management for inpatient and outpatient claims				
Mental Health and Substance Abuse Case Management				
Hospital bill audit program				
Maternity programs				
Tracking on-going treatments by specialists				
Large claim negotiations for out-of-network services				
Other services (please specify)				

7. Provide a summary of your internal quality assurance program including the criteria used to measure and access quality.

8. What criteria standard does your organization utilize in the utilization management process, including source(s) of these criteria, for pre-certification, establishing length of stay and determining medical necessity for inpatient confinements?

9. What percentage of pre-certification reviews are referred for physician review? What is the average turnaround time for such reviews?

10. What is the turnaround time for a pre-certification review?

11. Are you in compliance with the required determination timeframes for pre-service claims?

12. Describe the scope of your Case Management program.

13. How are potentially catastrophic cases identified and managed? What are the triggers/identifiers for a claim to be referred to case management?

14. What percentage of cases have historically been referred for case management?

15. How does your organization measure and report cost savings and quality improvement resulting from case management?

16. How does your organization communicate alternative medical and nutrition information?

17. Describe elements of your Case Management program that specifically target high-risk pregnancy and childbirth case management.

18. What are the procedures for appealing a utilization review decision, including how many levels of appeal you use, who participates on the appeal panel(s) and who are the final decision-makers at each level?

19. What is the turnaround time standard for responding to appeals?

20. What standard reports are available for your utilization management and case management programs? Provide samples, if any and frequency of each report.

21. Provide any information on additional utilization management services not specifically referenced above. Include brief program descriptions as well as any related fees.

VII. DISEASE MANAGEMENT QUESTIONNAIRE

GENERAL INFORMATION

1. How many years has your organization been providing disease management programs? Please confirm that these services are provided internally. If any services are subcontracted, please explain.

2. Please identify the number of members enrolled in your programs for 2022, 2023 and 2024.

3. Please describe your success rate of reaching participants and subsequently encouraging them to enroll in your programs. Please provide your target population for outreach and enrollment and your performance statistics for 2022, 2023, and 2024. Include a definition of an "enrolled member."

4. How does your organization encourage participation in disease management programs? What types of incentives have you found most effective?

5. Please describe your disease management staff. Please include level of training; education; requirements for ongoing education; member to clinician ratios; and turnover.

PROGRAM OVERVIEW

6. Please describe your disease management programs and your philosophy.
   - List each disease for which you offer a disease management program.
   - Identify how many years each disease program has been offered, how it was developed and how many members are currently participating in each program.
   - Describe any additional programs or enhancements planned in the future.

7. ATU has an on-site clinic for students. ATU faculty and staff are allowed to visit the on-site clinic under a copay, however, these claims are not filed under insurance currently. Please address if your organization can integrate Disease Management and Biometric Screening with the clinic, specifically as it relates to ongoing data feeds.

8. Describe your disease management process from data collection and referral to "graduation" from your program.
   - Identify specific milestones and responses to setbacks along the way.
   - Is the physician part of the process? Why or why not?

9. Would you consider your program patient-centered, care-centered, physician-centered, or health-plan centered? Please explain. Have you integrated your program with other models?

10. What policies and communication channels are in place to ensure that the participant's health care team (i.e., providers, registered nurses, health educators, social services, dietitians, pharmacists, physical therapist, occupational therapist, respiratory therapist, etc.) are continually updated regarding participant status?

11. How frequently does your organization contact providers and other members of the health care team to provide updates on participants?

12. If the care program outlined by the practicing physician is not in compliance with current practices and may not be the best appropriate (or most appropriate) care for that individual patient, how is the issue addressed with the attending physician? Do you have physicians on staff that conduct physician-to-physician discussions? Please describe your success in these situations.

13. Are providers involved in developing and defining best practice clinical guidelines?

14. Please identify the creative ways in which you have partnered with employers and their group plans. Have you implemented processes for maximizing participation and the successful completion of these programs by employees and their dependents?

15. Explain how disease management interventions are targeted to individual participants' needs and their motivation to change. Please explain any tools available to case managers that make your organization's approach more "scientific" versus "personal experience" based.

16. Which of the following variables are included in your disease management models:
    - Quality of life
    - Medical utilization
    - Cost
    - Disease-specific clinical indicators
    - Readmission rates
    - Admission rates
    - Length of stay
    - Emergency room usage
    - Office visit rate
    - Medication compliance
    - Other

17. Do you typically coordinate your disease management services with other services available in the community and/or other employer-sponsored programs?

18. Please describe in detail your ability and approach to managing behavioral health (mental health and substance abuse) cases as a stand-alone diagnosis and as co-morbidities.

19. Please describe your ability to manage co-morbidities and indicate specifically how your approach and processes may change based on their existence. For example, would a member be contacted more frequently? By different case managers?

20. Please describe your ability to manage members with soft tissue and self-diagnosed claims. Please explain your approach with these issues.

21. Please describe how case managers are assigned to a particular member. Describe the specialties available within your organization and if their background is matched with a particular diagnosis class for case management purposes.

22. Describe the roles and qualifications of your disease management staff (i.e., Medical Director, RNs, Health Educators, etc.) including program development, supervision, delivery and evaluation.

    a) What clinical practice guidelines are used in the program?
    b) How often are these guidelines updated?

23. Please describe the orientation process once a member has been identified to participate in the program and has agreed to participate. Please indicate any sign-offs, waivers, release forms, etc. that the member may need to sign in order to start the process. Please provide a sample orientation package in your response.

24. What type of initial and ongoing education and support do providers receive to understand clinical guidelines, program content, and impact monitoring?

PARTICIPANT IDENTIFICATION AND RECRUITMENT

25. Please explain how your "target" group is identified. Are members of the employee population stratified according to the severity of the condition and how does this get accomplished?

26. Indicate the data sources and any other methods you use to identify potential candidates for each disease management program.

27. Please describe your ability to identify specific risk factors by the existence of claims data and the lack of claims data (i.e., a member with diabetes not having annual eye exams).

28. Please describe the way you utilize and integrate prescription drug data to identify the "at risk" or chronically ill population.

29. Please describe the tools and models used to identify potential participants, assess their current health state and structure treatment plans on an automated basis. Does your system have the ability to "track" participants until they reach a state of compliance?

30. Once you have identified potential participants, how do you engage the individual and what is your enrollment process?

31. Can a participant make a self-referral?

32. Please describe your approach if there is "no answer" or "no response" upon outreach.

33. Please describe your approach if a member chooses not to participate. Please describe triggers for additional follow up and closure.

34. Define what member engagement means in your organization. What is your engagement percentage as a book of business?

35. After individuals are engaged and enrolled, what is your methodology to stratify participants by risk level based on health care utilization, health care costs, risk factors, and clinical indicators in order to match participants to the appropriate intensity of intervention?

36. How does your organization segment an employee population by health risk? How is this information used?
37. Indicate how your organization protects patient confidentiality and privacy.

COMMUNICATION

38. Communication is a very important component of successful disease management programs. Please describe your communication capabilities. Please provide a sample communications package.

39. Describe how your organization maximizes technology to reach members with education, resource tools, and other communication materials. Identify the utilization rate of each resource tool.

40. Please describe available educational resources related to preventive health care topics. Clarify if this information is available online, with a mobile app, etc.

41. Do you conduct annual participant, provider, and health plan surveys to gauge satisfaction levels? If yes, please report your results from the most recent surveys.

42. Are you willing to perform a satisfaction survey specific to ATU participants and network providers?

INFORMATION SYSTEMS

43. Do you have an automated system that develops tailored treatment plans? Is the model used as a tool to track progress, document member interaction and activity, and determine compliance? Please describe.

44. Do you have an automated assessment tool that your staff utilizes to monitor and work with patients? Please explain.

45. Please describe the specific systems enhancement planned to perfect the population assessment process.

46. List the measurement and evaluation studies your organization has completed or are in the process of conducting which indicate the impact of your programs.

47. Please describe your call tracking and member progress tracking software.

VIII. MISCELLANEOUS

PPO NETWORKS

1. What networks do you primarily work with on a regional basis? Will your selected network allow a narrower network selected by ATU to be an additional option?

2. Is repricing done online or are claims sent off? If sent off, what is the turnaround time for claim repricing? What procedures are in place to verify that all claims sent to the PPO for repricing are returned for processing?

3. Please describe your organizations willingness to negotiate contracts with providers identified in areas in which the network does not have sufficient coverage.

4. Describe any network changes that are being planned or implemented that would impact current network access.

5. When the on-site clinic is established, ATU may elect to pay claims for their facility as domestic at a discounted price outside the selected PPO network's pricing structure. Confirm your willingness to comply. Will you charge a process fee for these claims? If so, please disclose the fee.

IMPLEMENTATION

6. Provide an implementation plan that identifies your responsibilities and the assistance/activities that will be required from the employer.

7. What notifications, if any, do you send to participants regarding the change?

8. Provide a timetable for a January 1, 2026 effective date change with specific tasks for converting an employer's current medical plan to your system. Including implementation of the Benefit Administration System.

AFFORDABLE CARE ACT REQUIREMENTS

9. Describe the support your organization will provide to the employer regarding ACA reporting requirements for fully insured groups, i.e., 1094-C, 1095-C and 1094-B, 1095-B individual mandate reporting.

IX. ATU SPECIFIC QUESTIONS

1. Can the ATU logo be added to the ID card?

2. Can your organization create and maintain the Plan Documents and SPD? What is the process for updating/amending?

PREFERRED CONTRACTUAL PROVISIONS

SERVICES

During the term of this Agreement, your organization shall provide for ATU the goods and services offered to ATU by your organization in its proposal and/or any addenda to its proposal and as specified by ATU when it selected the organization.

CLIENT AUTHORIZED REPRESENTATIVE

The only persons who are or shall be authorized to speak or act for ATU in any way with respect to this Agreement are those whose positions or names have been specifically designated in writing to the Selected Organization by ATU. Final authority for purchasing decisions rests with ATU.

WAIVER

No waiver of any right hereunder shall be deemed a continuing waiver, and no failure on the part of either party to exercise wholly or in part any right hereunder shall prevent a later exercise of such or any other right.

INDEMNIFICATION

The selected Organization shall indemnify and hold harmless ATU and the employees and agents of each, from all property damage or loss, claims, liability, damages, expenses (including, without limitation, attorneys' fees and expenses) and any other amounts arising out of the performance of the Agreement by the Selected Organization.

GOVERNING LAW

This Agreement is subject to the laws of the State of Arkansas.

TERMINATION

If the Selected Organization fails to provide quality goods and services in a professional manner solely as determined by ATU and, upon receipt of notice from ATU, does not correct the deficiency within a reasonable period of time not to exceed thirty calendar days, unless otherwise agreed to by both parties, ATU reserves the right to terminate this Agreement by giving written notice to the Selected Organization.

TAXES

ATU is exempt from Federal excise and all state and local taxes. Such taxes shall not be included in contract prices. Tax-exempt certificates will be furnished on request by the issuing office.

INSURANCE

The Selected Organization shall provide to ATU within 10 days after the contract is awarded a valid certificate of insurance listing the insurance coverage maintained. The liability insurance coverage maintained by the Selected Organization shall include, but is not limited to, the following coverage:

- Premises - Operations
- Contractual
- Personal Injury
- Cyber Liability
- Commercial General Liability Insurance (CGL):
    - Organization is responsible for carrying Commercial General Liability insurance including Contractual Liability per CG0001 (12/07 or equivalent), with limits not less than $1,000,000 Each Occurrence and $2,000,000 in the aggregate for bodily injury and third party property damage including products and completed operations.
    - Such coverage shall name ATU and all subsidiaries as additional insured. Such coverage will be on a primary and non-contributory basis for both ongoing and completed operations and shall include a waiver of subrogation in favor of ATU and all subsidiaries.
    - Organization will provide the ATU with certificates of insurance evidencing CGL written by insurance companies with A-VII or better AM Best rating.
- Professional Liability/ Errors and Omissions, including coverage for claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security with limits not less than $1,000,000.

OTHER REQUIREMENTS

The Selected Organization shall provide to ATU within 10 days after the contract is awarded the following documents to be provided by ATU at time of award:

- Illegal Immigrant Certification
- Non-Disclosure Agreement
- Business Associates Agreement
- Contract and Grant Disclosure & Certification Form
- Boycott of Israel Certificate
- Technical and General Services Contract
- EEO Policy Certification

EXHIBIT A

Benefit Eligible Employees/Retirees

Full-Time Employees

Benefits are offered to Full-Time employees who work a minimum of 30 hours per week. Benefits for new hires begin the first of the month following date of hire.

Retirees

- Pre-65 Retirees - Retirees upon attaining age 60 and completing 10 years of service are eligible to continue medical benefits as active employees until they are Medicare eligible.

- Post-65 Retirees – Retirees who retired before July 1, 1998 are "Grandfathered" and eligible to continue benefits including coverage for their spouse until they choose to dis-enroll or until their death.

Part-Time Employees

- ATU abides by the ACA guidelines regarding part-time employees.

EXHIBIT B

Current Benefit Designs

Full-Time Employees
Full-Time Employees have two options to choose from 1) PPO - $3,000 or 2) HDHP $4,000

Retirees

There are two classes of Retirees as broken down below. They can choose to enroll in the current benefit options offered to full-time employees.

- Pre 65 Retirees can retire if they are 60+ years old and have 10 years of service. Benefits end the last day of the month prior to their 65th birthday or when they become Medicare eligible.

- Post 65 Retirees are "Grandfathered". They can keep their insurance until death. There are 12 employees covered in this population.

- Benefit Summaries follow.

PPO $3,000 Summary

Offered to Full-Time employees and Retirees

Descriptions	Your Portion
Individual Deductible: A dollar amount that you pay for healthcare services before the health plan begins to pay. Every policy has an individual or family deductible. If you are the only person on your policy, then you will pay for healthcare costs covered by your plan until you meet your individual deductible. Family deductibles work differently.	**$3,000** In-network **$9,000** Out-of-network
Family Deductible: If you or anyone in your family meets the individual deductible, then your health plan will begin to pay a portion of medical expenses for that person for that calendar year (also called coinsurance). However, when the family deductible is met by any combination of family members, coinsurance will pay on all family members. *Continues on page four.*	**$6,000** In-network **$18,000** Out-of-network

Coinsurance: A percentage of all remaining eligible medical expenses that is your responsibility to pay after your deductible has been satisfied.

Copayment: The amount you're required to pay to a preferred provider for covered medical expenses.

Annual Limit on Cost Sharing: The claims amount that you must pay in a calendar year before you're no longer expected to pay copayments, deductible or coinsurance for the remainder of the year. The annual limitation on cost sharing is outlined in the Schedule of Benefits.

Annual Limit on Cost Sharing

	Individual	Family
In-Network	$6,000	$12,000
Out-of-Network*	$18,000	$36,000

**Annual limit on out-of-network costs does not include copayments.*

Service Type**		Your Cost In-network coinsurance	Your Cost Out-of-network coinsurance
Professional Services			
Primary care physician visit	Copayment amount $40	0%	50%
Specialty physician visit (Coinsurance may apply to additional services)	Copayment amount $80	30%	50%
Adult preventive services		0%	20%
Children's preventive services		0%	20%
Professional fees for inpatient surgical and medical services		30%	50%
Professional fees for outpatient surgical and medical services		30%	50%
Hospital and Other Medical Facility Services			
Inpatient services		30%	50%
Outpatient services (Includes surgery, diagnostics, lab and X-ray)		30%	50%
Emergency room visit		30%	30%
Maternity and obstetrics		30%	50%
Therapeutic Services			
Inpatient (limited to 60 days)		30%	50%
Outpatient (limited to 30 visits total)	Copayment amount $40	0%	50%
▪ Physical, occupational and speech therapy	Copayment amount $80	30%	50%
▪ Chiropractic			
Other Services			
Durable medical equipment***		30%	50%
Diabetic supplies		30%	50%
Mental health		30%	50%
Ambulance services — Ground		30%	30%
— Air		30%	30%

***Additional fees may apply. Please check your Benefit Certificate. *** Prior approval required for durable medical equipment that exceeds $5,000.*

Important Disclaimer from Arkansas Blue Cross and Blue Shield

This document is intended only to highlight your benefits and should not be relied on to fully determine coverage. **Some of the above services are subject to visit, day and/or dollar limits.** Please refer to your Benefit Certificate for a full explanation of your benefits, the limitations of these benefits

PPO $3,000 Prescription Drug Summary

ARKANSAS TECH UNIVERSITY

Arkansas BlueCross BlueShield

Your Drug Coverage

Your prescription drug benefit is an important part of your health coverage. There are often lower-cost options available; ask your doctor for alternatives.

All **preventive** prescription drugs are covered in full.

Generic drugs will cost less and have lower copayments. Selecting generic drugs is a way to save money on your overall healthcare expenses.

Preferred brand-name drugs will cost less and will have lower copayments than **non-preferred brand-name** drugs.

Non-Preferred brand-name drugs are more expensive drugs. **Specialty** drugs typically require defined handling and home storage demands, crucial patient education and careful monitoring.

Your coverage features a mail order option that may offer savings on drugs that have been prescribed on an ongoing basis. Check your [Benefit Certificate/ Certificate of Coverage/Schedule of Benefits] for details.

Copayments by Category

**One copayment per 100-day supply*

Preventive	Generic	Preferred Brand	Non-preferred Brand	Specialty
Covered in full	$20.00	$50.00	$70.00	$250.00
Mail order*	$40.00	$100.00	$140.00	$500.00

HDHP (HSA eligible) Summary

Offered to Full-Time employees and Retirees

Benefit Summary — BC 4000-100_HDHP_E - (1)

Arkansas BlueCross BlueShield

ARKANSAS TECH UNIVERSITY — Effective Date: 01/01/2024

Descriptions	Your Portion In-Network	Your Portion Out-of-Network
Individual Deductible: A dollar amount that you pay for healthcare services before the health plan begins to pay. Every policy has an individual and family deductible. If you are the only person on your policy, then you will pay for healthcare costs covered by your plan until you meet your individual deductible. Family deductibles work differently.	$4,000	$8,000
Family Deductible: If you or anyone in your family meets the individual deductible, then your health plan will begin to pay a portion of medical expenses for that person for that calendar year (also called coinsurance). However, when the family deductible is met by any combination of family members, coinsurance will pay on all family members. *Continues on back page.*	$8,000	$16,000

Coinsurance: A percentage of all remaining eligible medical expenses that is your responsibility to pay after your deductible has been satisfied.

Copayment: The amount you're required to pay to a preferred provider for covered medical expenses.

Annual Limit on Cost Sharing: The claims amount that you must pay in a calendar year before you're no longer expected to pay deductible or coinsurance for the remainder of the year. The annual limitation on cost sharing is outlined in the Schedule of Benefits.

Annual Limit on Cost Sharing	Individual	Family
In-Network	$4,000	$8,000
Out-of-Network	$16,000	$32,000

Service Type**	Your Cost In-network coinsurance	Your Cost Out-of-network coinsurance
Professional Services		
Primary care physician visit	0%	20%
Specialty physician visit	0%	20%
Adult wellness (deductible does not apply in network)	0%	20%
Children's preventive health services (deductible does not apply in network) immunizations covered 100%	0%	20%
Professional fees for inpatient surgical and medical services	0%	20%
Professional fees for outpatient surgical and medical services	0%	20%
Hospital and Other Medical Facility Services		
Hospital visit (inpatient)	0%	20%
Hospital (outpatient) includes surgery, diagnostics and therapeutic care	0%	20%
Emergency room visit	0%	0%
Maternity and obstetrics	0%	20%
Other Services		
Durable medical equipment	0%	20%
Diabetic supplies	0%	20%
Mental health**	0%	20%
Therapeutic services — Physical and occupational**	0%	20%
— Chiropractic	0%	20%
Speech**	0%	20%
Ambulance services — Ground	0%	0%
— Air	0%	0%
Retail pharmacy - Standard with Step w/Prev Rx - subject to deductible	0%	non-covered

***Visit limitations may apply to some service types. Please check your Benefit Certificate.*

BC 4000-100_HDHP_E - (1)

Important Disclaimer from Arkansas Blue Cross and Blue Shield

This document is intended only to highlight your benefits and should not be relied on to fully determine coverage. **Some of the above services are subject to visit, day and/or dollar limits.** Please refer to your Benefit Certificate for a full explanation of your benefits, the limitations of these benefits and the services that are not covered. If this document conflicts in any way with the policy issued to your employer, the policy shall prevail.

1

PPO 950

Grandfathered Post-65 Retirees

Descriptions	Your Portion
Individual Deductible: A dollar amount that you pay for healthcare services before the health plan begins to pay. Every policy has an individual or family deductible. If you are the only person on your policy, then you will pay for healthcare costs covered by your plan until you meet your individual deductible. Family deductibles work differently.	**$950** (Combination of both in-network and out-of-network medical expenses)
Family Deductible: Each family member on your plan has an individual deductible. When two family members have met their individual amounts, then the entire family's deductible has been met for that calendar year and your health plan will begin to pay a portion of your medical expenses (also called coinsurance). *See example on page four.*	**$1,900** (Combination of both in-network and out-of-network medical expenses)

Coinsurance: A percentage of all remaining eligible medical expenses that is your responsibility to pay after your deductible has been satisfied.

Copayment: The amount you're required to pay to a preferred provider for covered medical expenses.

Annual Limit on Cost Sharing: The claims amount that you must pay in a calendar year before you're no longer expected to pay copayments, deductible or coinsurance for the remainder of the year. The annual limitation on cost sharing is outlined in the Schedule of Benefits.

Annual Limit on Cost Sharing

	Individual	Family
In-Network	$3,450	$6,900
Out-of-Network*	No Limit	No Limit

**Annual limit on out-of-network costs does not include copayments.*

Service Type**	Your Cost In-network coinsurance	Your Cost Out-of-network coinsurance
Professional Services		
Primary care physician visit — Copayment amount $35	0%	40%
Specialty physician visit (Coinsurance may apply to additional services)	20%	40%
Adult preventive services	0%	20%
Children's preventive services	0%	20%
Professional fees for inpatient surgical and medical services	20%	40%
Professional fees for outpatient surgical and medical services	20%	40%
Hospital and Other Medical Facility Services		
Inpatient services	20%	40%
Outpatient services (Includes surgery, diagnostics, lab and X-ray)	20%	40%
Emergency room visit	20%	20%
Maternity and obstetrics	20%	40%
Therapeutic Services		
Inpatient (limited to 60 days)	20%	40%
Outpatient (limited to 30 visits total) — Copayment amount $35		
▪ Physical, occupational and speech therapy	0%	40%
▪ Chiropractic	20%	40%
Other Services		
Durable medical equipment***	20%	40%
Diabetic supplies	20%	40%
Mental health	20%	40%
Ambulance services — Ground: up to $1,000 per trip	20%	20%
— Air: up to $5,000 per trip	20%	20%

Grandfathered Post-65 Retiree Prescription Drug Summary

ARKANSAS TECH UNIVERSITY

Arkansas BlueCross BlueShield

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Your coverage features a mail order option that may offer savings on drugs that have been prescribed on an ongoing basis. Check your [Benefit Certificate/ Certificate of Coverage/Schedule of Benefits] for details.

Copayments by Category

Preventive	Generic	Preferred Brand	Non-preferred Brand
Covered in full	$15.00	$45.00	$65.00
Mail order*	$15.00	$45.00	$65.00

*One copayment per 100-day supply

EXHIBIT C
2026 Renewal Information

History

2010-Rate Hold
2011 – 7%
2012 – 4.7%
2013 – 0.2%
2014 – 8.5%
2015 – 8% increase after benefit changes
2016 – 9.7% rate increase
2017 – 6% decrease after benefit changes
2018 – 7.9%
2019 – 24.2%
2020 – 17% with benefit changes
2021 – Rate Hold - .04% for contract extension to 3/1/2021
2022 – Minus 2.6% decrease
2023 – 1.5% increase
2024 – 2.6% increase including a commission service fee of 1%
2025 – 2.3% increase

Additional Information

- Pooling Level - $250,000
- 12 month rolling loss ratio – 112%
- 1% Commission included in rates
- Average Census
  - EE – 470
  - ES – 39
  - EC – 95
  - FAM – 74

Renewal Rates

Tier	#	PPO 3000	#	HDHP 4000	#	Post 65 PPO	
EE	278	$820.51	181	$816.22	11	$958.60	
ES	20	$1592.03	18	$1583.66	1	$1919.85	
EC	67	$1141.75	28	$1135.75	0	$1589.64	
FAM	43	$1928.73	31	$1918.51	0	$2611.00	
Total	408		258		12		678

EXHIBIT D

Reporting, Census, & Renewal

Claims vs premium and high cost member reporting, census information, & renewal are available upon request and will be sent securely as a separate attachment. For inquiries, please refer to page #6 for contact information.