EMERALD COAST UTILITIES AUTHORITY

PROPOSAL FORMS PACKAGE
FOR
EMPLOYEE INSURANCE AND BENEFITS
RFP #2018-05

PROPOSALS DUE
2:00 P.M., CENTRAL TIME
TUESDAY, APRIL 10, 2018

PROPOSAL FORMS PACKAGE

Emerald Coast Utilities Authority
RFP# 2018-05 Employee Insurance and Benefits

This proposal forms package is constructed to facilitate the Emerald Coast Utilities Authority's review of proposals received. Three (3) proposals are to be submitted: one (1) paper original and two (2) paper copies (a total of three) along with one (1) CD-ROM or USB flash drive of the complete proposal. The CD-ROM or USB flash drive must contain your proposal in Microsoft Word, and all proposal attachments in the appropriate format, Microsoft Word and/or Microsoft Excel. The paper original shall be the governing document.

No one is authorized to use the proposal forms for RFP 2018-05 for any purpose other than to respond to this specific RFP. No one is authorized to alter the proposal form content; such alteration could result in disqualification of the proposal. Thank you for your cooperation. It will greatly facilitate the Emerald Coast Utilities Authority's review of your proposal.

To be responsive, complete these Proposal Forms for your proposal, as the information applies. Your Proposal Forms should be typed. A Word version of the Proposal Forms will be sent to the email address provided to Amy Williamson, Senior Purchasing Agent. Corrections, if any, to your typed forms should be made in ink and initialed.

COVERAGE DETAILS AND CLAIMS DATA

Coverage details and claims data reports are included as appendixes to RFP# 2018-05. The information is being provided in its original format. If you have any issue with receipt of the information, contact Amy Williamson, Senior Purchasing Agent at amy.williamson@ecua.fl.gov no later than April 10, 2018.

AVOID VAGUE TERMS

The use of N/A should be avoided. N/A can mean several things: Not Available; Not applicable; Not applicable for varied reasons, etc. Instead, please use "Included," "Not Included," or "Not Proposed."

Avoid using "See Proposal." This Proposal Forms Package is your proposal. When referring to an appendix or schedule, please note where in your proposal the information can be found.

EXCEPTIONS

All exceptions, if any, shall be clearly identified, and written explanations shall include the scope of the exceptions, the ramifications of the exceptions for the ECUA and a description of the advantage to be gained or disadvantages to be incurred by the ECUA as a result of these exceptions. (See page PF-7, "Exceptions," to provide detail)

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PROPOSAL FORMS PACKAGE

RFP 2018-05 EMPLOYEE INSURANCE AND BENEFITS

ECUA's 2016 COMPREHENSIVE ANNUAL FINANCIAL REPORT (CAFR)
The report can be accessed via ECUA's Internet site at www.ecua.fl.gov. Hover your mouse over "News & Reports" to view the drop-down menu and select "Reports," then scroll to locate "2016 Comprehensive Annual Financial Report."

Emerald Coast Utilities Authority
RFP# 2018-05 Employee Insurance and Benefits

QUESTIONNAIRE

General Information Required of All Proposers

For evaluation of the proposals, it is essential that the following be included in the submission:

1. Entity Name
2. Name and Title of Contact
3. Email Address
4. Toll Free Phone
5. Phone
6. Fax
7. Street Address
8. Scope of Services included in your proposal (check all that apply):
   ☐ Group Medical Insurance ☐ Group Dental Insurance ☐ Group Vision Insurance
9. Did you receive the coverage details and claims data reports included as appendixes to RFP# 2018-05 and the 2016 Comprehensive Annual Financial Report (CAFR)?
10. Are you licensed to do business in the State of Florida? If so, a copy of licensure must be included in proposal submission.
11. Have you, as of the proposal due date, been successfully operating for a minimum of five consecutive years?
12. Will you accept an October 1, 2018 effective date?
13. Do you agree to provide a rate guarantee for the quoted pricing and contract effective dates?
14. Do you agree to the insurance requirements listed in the RFP?
15. Does your proposal submission include one (1) original and two (2) copies along with one (1) CD-ROM or USB flash drive?
16. Will your proposal be valid for ninety (90) days from the proposal due date?
17. Is a **sample** service agreement/contract provided (attached) for analysis?
18. Is a 60-day notice to the ECUA of any renewal rate increases for the specified services included in your proposal?
19. Is a 90-day notice of termination to the ECUA included in your proposal?
20. Is a 30-day notice of termination by ECUA acceptable?
21. Can the service agreement with ECUA be cancelled mid-year for any reason other than non-payment? If so, for what reason(s)?
22. Have you provided a quote which discloses all fees?
23. Have you completed and submitted the Reference Form?
24. List here the name(s) of any officer, director or agent of your company who is also an employee of ECUA. (If none, state "None.")
25. List here the name(s) of any ECUA employee(s) who owns, directly or indirectly, an interest of five percent or more in the proposer's company or any of its branches. (If none, state "None.")

26. Describe in detail the proposer's experience and qualifications to meet the requirements of ECUA. Details should include:
    a. Number of years providing group insurance and benefits
    b. Location of corporate headquarters
    c. Location of the nearest company group sales and claims offices that will handle this contract.
    d. Name and location of the company group representative who will service this contract.
    e. Will one or more claims handlers be assigned this contract in your claims office?
    f. What is your current A. M. Best rating or equivalent?
    g. Description of how you have provided employee insurance and/or benefits for public entities
27. What is your history in transitioning organizations from other insurers/providers to your firm?
28. Provide a proposed transition plan and implementation timeline and describe how you will manage ECUA's transition from its current provider(s) to your company.
29. Describe to what extent you will cover the cost of fees related to the transition of deductible and claims data to your company?
30. Identify any service(s) you intend to subcontract to others and identify the proposed subcontractors, including names, phone numbers and the qualifications of the subcontractors.
31. Has the quote been issued net of commissions? If not, please disclose commission information.
32. Are you willing to assign a dedicated representative to ECUA's account?
33. What are your hours of operation? Time zone?
34. Describe your customer satisfaction and how concerns are addressed and resolved.
35. Describe your ability to work in conjunction with ECUA Human Resources representatives to resolve claims issues for ECUA employees.
36. What training is included in the services you would provide ECUA? If included, how is training provided (e.g., on-site, web, etc.)? Are there additional costs associated with this training?
37. Is a web-based portal included in your proposal/fee? If not, state the additional cost for online access.
38. Are aggregate claims data and enrollment reports available via your web-based portal and included in your standard fee? Describe the standard reports in detail and provide a few sample reports. If reports are not included in your standard fee, state if they can be made available and how the cost is calculated.
39. Do you agree to be responsible for and comply with all rules and regulations required by PPACA, ERISA, HIPAA, governmental reporting, etc.?
40. Describe the Dependent Eligibility Verification audit process.
41. Do you conduct periodic dependent eligibility verifications? If so, describe the verification process and state the frequency.
42. Do you offer enrollment options both online and hard copy, if needed? If so, describe the open enrollment process.

43. Do you provide an enrollment option which allows the carrier database to be updated via importing enrollment data? If so, describe the import process.
44. Do you offer online access to the carrier database? If so, describe the features of this access.
45. Are you able to provide renewal information in February of each year for a plan year which begins in October? If not, in what month will you provide ECUA staff with renewal information?
46. Will you provide monthly utilization, large claims, and loss ratio reports?
47. Are you willing to meet on a quarterly basis with ECUA staff and its Benefits Consultant, if applicable, to discuss claims (including large claims), loss ratio, trends, changes, and general administrative matters?
48. The education and enrollment phase will begin in August 2018. The enrollment will be an open enrollment. Please state your capability to educate and enroll the ECUA's group prior to the plan effective date of October 1, 2018.
49. Please state your capability to attend and present your benefits at up to 20 on-site enrollment meetings during the open enrollment period prior to the plan effective date of October 1, 2018.
50. Describe your quality assurance audit program including the areas that are audited, frequency of audits, and corrective action on areas needing improvement.
51. Indicate your willingness to agree to a performance guarantee, subject to mutual agreement between your company and ECUA. Include your suggestions regarding the performance areas to be measured, how they would be measured and at what intervals. Include a sample of your standard performance guarantee.
52. Describe your process for data transmittal at the end of your service agreement period including format for data to be provided to ECUA and conversion assistance when converting data to a new provider. Include any fees associated with this service.

Group Medical Insurance Information Required based on Proposed Insurance/Service

53. Provide a detailed list of covered services by plan.
54. Complete the forms on pages PF-8 and PF-9 to propose plan options. Proposers are encouraged to be as creative as possible and submit multiple plans. All proposals should include a full benefit summary for proposed plans.
55. Describe the pharmacy benefits and provide prescription drug list.
56. Describe your PPACA compliance process.
57. Describe your network and provide network listing.
58. Provide a Geo Access report that illustrates the number of:
    a. Hospital within 10 miles
    b. PCPs & Pediatricians within 10 miles
    c. OBs/GYNs, within 10 miles
    d. Specialists within 10 miles
    e. Urgent Care Centers within 10 miles
59. Describe out-of-network benefits covered by plan.
60. State whether the "deductible year" coincides with the "plan year" and specify the dates of the plan year and deductible year.

61. Does your proposal include a Wellness Program? If so, describe program and any related costs.
62. Fully disclose retiree coverage amounts and rates.
63. Provide any additional information related to proposed plans.

Group Dental Insurance Information Required based on Proposed Insurance/Service

64. Provide a detailed list of covered services by plan.
65. Complete the table on pages PF-10 and PF-11 to propose plan options. Proposers are encouraged to be as creative as possible and submit multiple plans. All proposals should include a full benefit summary for proposed plans.
66. Describe how your reimbursement rate (UCR) is calculated for in-network and out-of-network charges.
67. Describe your network and provide network listing.
68. Provide a Geo Access report that illustrates the number of:
    a. General Dentists within 10 miles
    b. Specialty Dentists within 10 miles
    c. Orthodontists within 10 miles
69. Describe out-of-network benefits covered by plan.
70. What are the reimbursement rates for panoramic x-ray, cleaning, root canal, and composite filling? Include rates for in-network and out-of-network providers.
71. State whether the “deductible year” coincides with the “plan year” and specify the dates of the plan year and deductible year.
72. Fully disclose retiree coverage amounts and rates.
73. Provide any additional information related to proposed plans.

Group Vision Insurance Information Required based on Proposed Insurance/Service

74. Provide a detailed list of covered services by plan.
75. Complete the table on page PF-12 to propose plan options. Proposers are encouraged to be as creative as possible and submit multiple plans. All proposals should include a full benefit summary for proposed plans.
76. Describe your network and provide network listing.
77. Describe out-of-network benefits covered by plan.
78. Provide any additional information related to proposed plans.

HEALTH INSURANCE PLAN 5 MATCH
PROPOSED SCHEDULE OF BENEFITS

Schedule of Benefits	Current Plan *UHC Choice Plus (FMIT Plan 005)*		Proposed Plan	
Lifetime Maximum	Unlimited			
Deductible	***In Network***	***Non-Network***		
Single	$1,300	$2,500		
Family	$2,600	$5,000		
Out of Pocket Maximum	*Incl. CYD, Coinsurance, Copays & Rx*			
Single	$3,750	$7,500		
Family	$7,500	$15,000		
Coinsurance	10%	30%		
Office Visits				
Physician Office Visit	10% after CYD	30% after CYD		
Specialist Visit	10% after CYD	30% after CYD		
Preventive Services	No Charge	Not Covered		
Independent Clinical Lab	10% after CYD	30% after CYD		
Advanced Imaging	10% after CYD	30% after CYD		
Urgent Care Center	10% after CYD	30% after CYD		
Hospital				
Inpatient	10% after CYD	30% after CYD		
Outpatient	10% after CYD	30% after CYD		
Emergency Room Visit	10% after CYD	10% after CYD		
Physician Services at Hospital	10% after CYD	30% after CYD		
Mental Health/Substance Abuse				
Inpatient	10% after CYD	30% after CYD		
Outpatient	10% after CYD	30% after CYD		
Prescription Drugs				
Generic	$10	Member pays difference to network cost, less Network copay amount		
Brand Name	$35			
Non-Preferred Brand	$60			
Mail Order (90 day supply)	2.5x			

HEALTH INSURANCE PLAN 14 MATCH
PROPOSED SCHEDULE OF BENEFITS

Schedule of Benefits	Current Plan *UHC Choice Plus (FMIT Plan 014)*		Proposed Plan	
Lifetime Maximum	Unlimited			
Deductible	***In Network***	***Non-Network***		
Single	$1,000	$1,000		
Family	$2,000	$2,000		
Out of Pocket Maximum	*Incl. CYD, Coinsurance, Copays & Rx*			
Single	$4,000	$6,000		
Family	$8,000	$12,000		
Coinsurance	20%	30%		
Office Visits				
Physician Office Visit	$25	30% after CYD		
Specialist Visit	$50	30% after CYD		
Preventive Services	No Charge	Not Covered		
Independent Clinical Lab	No Charge	30% after CYD		
Advanced Imaging	20% after CYD	30% after CYD		
Urgent Care Center	$35	30% after CYD		
Hospital				
Inpatient	20% after CYD	30% after CYD		
Outpatient	20% after CYD	30% after CYD		
Emergency Room Visit	$200	$200		
Physician Services at Hospital	20% after CYD	30% after CYD		
Mental Health/Substance Abuse				
Inpatient	20% after CYD	30% after CYD		
Outpatient	$25	30% after CYD		
Prescription Drugs				
Generic Brand Name Non-Preferred Brand Mail Order (90 day supply)	$10 $35 $60 2.5x	Member pays difference to network cost, less Network copay amount		

DENTAL INSURANCE LOW OPTION PLAN MATCH
PROPOSED SCHEDULE OF BENEFITS

Schedule of Benefits	Current Plan		Proposed Plan	
	In Network	Out of Network	In Network	Out of Network
Calendar Year Maximum	$1,000			
Orthodontia Lifetime Max	$1,000			
Calendar Year Deductible				
Single	$50	$50		
Family Aggregate	$100	$100		
Is Deductible waived for Preventive Services?	Yes	Yes		
Benefits Payable				
Preventive	100%	100%		
Basic	80%	80%		
Major	50%	50%		
Endodontics & Periodontics Coverage Level	Basic	Basic		
Orthodontic Treatment	50%	50%		
Out of Network Benefits paid at:	90^{th} percentile			

DENTAL INSURANCE HIGH OPTION PLAN MATCH
PROPOSED SCHEDULE OF BENEFITS

Schedule of Benefits	Current Plan		Proposed Plan	
	In Network	Out of Network	In Network	Out of Network
Calendar Year Maximum	$1,500			
Orthodontia Lifetime Max	$1,500			
Calendar Year Deductible				
Single	$50	$50		
Family Aggregate	$100	$100		
Is Deductible waived for Preventive Services?	Yes	Yes		
Benefits Payable				
Preventive	100%	100%		
Basic	80%	80%		
Major	50%	50%		
Endodontics & Periodontics Coverage Level	Basic	Basic		
Orthodontic Treatment	50%	50%		
Out of Network Benefits paid at:	90^{th} percentile			

VISION INSURANCE PLAN MATCH
PROPOSED SCHEDULE OF BENEFITS

Schedule of Benefits	Current Plan The Standard – VSP		Proposed Plan	
	In-Network	***Non-Network***	***In Network***	***Non-Network***
Exam Deductible	$10			
Materials Deductible	$10			
Frequency				
Exam	12 months			
Lenses	12 months			
Frames	24 months			
Benefits Payable	***Copay***	***Reimbursement***		
Eye Exam	No Charge	$45		
Single Lenses	No Charge	$30		
Bifocal Lenses	No Charge	$50		
Trifocal Lenses	No Charge	$65		
Lenticular Lenses	No Charge	$100		
Lenses and Frames	***Reimbursement***	***Reimbursement***		
Contact Lenses (Elective)	$130 allowance	$105		
Contact Lenses (Medically Necessary)	No Charge	$210		
Frames	$130 allowance	$70		

PRICING/RATE PROPOSAL
RFP# 2018-05

1. ECUA requests monthly billing. Do you agree to bill monthly? State your methods for billing (i.e., list bill or self-bill) and accepted means of payment.
2. Present your pricing structure in a table format. Disclose all rates and fees. A four tier (Employee, Employee + Spouse, Employee + Child(ren), and Employee + Family) pricing structure is requested, if applicable.
    a. Medical Insurance
    b. Dental Insurance
    c. Vision Insurance
3. Specify if your pricing is contingent upon multiple lines of coverage.
4. If your proposal contains multiple lines of coverage, please also include "unbundled" pricing/rates for each line of coverage included in your proposal.
5. Are any discounts offered based on favorable program results or performance? If so, please describe.
6. For what period is the quoted pricing guaranteed? Is a longer pricing guarantee available?
7. What contingencies, if any, are attached to your pricing proposal?
8. Describe any costs associated with conversion.
9. At renewal, what information will you require from ECUA to develop renewal rates?
10. Provide any additional information related to proposed pricing.

EXCEPTIONS

	Yes No
Does your proposal include exceptions to this RFP? If yes, list the exceptions to this RFP with explanation below.	___ ___

Exceptions include the whole proposal document, our specifications, instructions to proposers and general provisions.

Please list the exceptions to this document with explanation:

AUTHORIZED REPRESENTATIVE

I read the Emerald Coast Utilities Authority Request for Proposals (#2018-05), I understand the scope of services requested and requirements stated, and I am either complying with the scope of services and requirements or indicating the specific items with which I cannot comply. In cases of noncompliance, where possible, I offered an alternate solution.

The Request for Proposals by the ECUA is understood to be a request for proposal from providers of employee insurance and benefits which may be accepted by ECUA for formation of a valid and binding contract. I represent that I am authorized to make such an offer on behalf of the proposed firm.

NAME: _____ _____

Signed Printed

TITLE: _____

ADDRESS: _____

_____

_____

_____

TELEPHONE : ( )_____

FAX NUMBER: ( )_____

(VERY IMPORTANT) EMAIL: _____

EMERALD COAST UTILITIES AUTHORITY

RFP 2018-05

REFERENCES FORM

To be responsive, proposers are required to provide the reference information for three (3) current clients and three (3) former clients. Organizations should be of similar size to ECUA.

Current Clients

1. Organization:
Contact Person and Title:
Email Address: Phone:
Contract Period:
Scope of Service:

2. Organization:
Contact Person and Title:
Email Address: Phone:
Contract Period:
Scope of Service:

3. Organization:
Contact Person and Title:
Email Address: Phone:
Contract Period:
Scope of Service:

Former Clients

4. Organization:
Contact Person and Title:
Email Address: Phone:
Contract Period:
Scope of Service:
State reason(s) for the discontinuance:

5. Organization:
Contact Person and Title:
Email Address: Phone:
Contract Period:
Scope of Service:
State reason(s) for the discontinuance:

6. Organization:
Contact Person and Title:
Email Address: Phone:
Contract Period:
Scope of Service:
State reason(s) for the discontinuance:

EQUAL OPPORTUNITY CLAUSE

During the performance of this contract, the contractor agrees as follows:
(1) The contractor will not discriminate against any employee or applicant for employment because of race, color, creed/religion, sex, national origin, disability/handicap, age, marital status, veteran status, or any other legally protected status. The contractor will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, creed/religion, sex, national origin, disability/handicap, age, marital status, veteran status, or any other legally protected status. Such action shall include, but not be limited to the following: Employment, upgrading, demotion, or transfer, recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

(2) The contractor will in all solicitations or advertisements for employees placed by or on behalf of the contractor; state that all qualified applicants will receive consideration for employment without regard to race, color, creed/religion, sex, national origin, disability/handicap, age, marital status, veteran status, or any other legally protected status.

(3) The contractor will send to each labor union or representative of workers which he has a collective bargaining agreement or other contract or understanding, a notice advising the labor union or workers' representative of the contractor's commitments under Section 202 of Executive Order 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

(4) In the event of the contractor's noncompliance with the nondiscrimination clauses of this contract or with any of such rules, regulations, or orders, this contract may be cancelled, terminated or suspended in whole or in part and the contractor may be declared ineligible for further contracts with the Emerald Coast Utilities Authority. Provided, however, that no such action shall be taken without prior notice to the contractor and an opportunity for a hearing before the governing Board of the Emerald Coast Utilities Authority or its designee.

(5) The contractor will include the provisions of paragraphs (1) through (4) in every subcontract or purchase order for an amount exceeding ten thousand dollars ($10,000) in any twelve (12) month period, so that such provisions will be binding upon each subcontractor or vendor.

_____ _____

Signature Date

_____

Name & Title of Signer

CERTIFICATION OF NONSEGREGATED FACILITIES

By the submission of this bid, the bidder, offeror, applicant, or subcontractor certifies that he does not maintain or provide for his employees any segregated facilities at any of his establishments, and that he does not permit his employees to perform their services at any location under his control, where segregated facilities are maintained. He certifies further that he will not maintain or provide for his employees any segregated facilities at any of his establishments, and that he will not permit his employees to perform their services at any location, under his control, where segregated facilities are maintained. The bidder, offeror, applicant, or subcontractor agrees that a breach of this certification is a violation of the Equal Opportunity Clause in this contract. As used in this certification, the term "segregated facilities" means any waiting rooms, work areas, rest rooms and wash rooms, restaurants and other eating areas, time clocks, locker rooms and other storage or dressing areas, parking lots, drinking fountains, recreation or entertainment areas, transportation, and housing facilities provided for employees which are segregated by explicit directive or are in fact segregated on the basis of race, color, creed/religion, national origin, age, marital status, or veteran status because of habit, local custom, or otherwise. He further agrees that (except where he has obtained identical certifications from proposed subcontractors for specific time periods) he will obtain identical certifications from proposed subcontractors prior to the award of subcontracts or purchase orders exceeding $10,000; that he will retain such certifications in his files and make them available to the Emerald Coast Utilities Authority upon request.

Provided, however, that such certifications shall not be required in the case of purchase orders or contracts which, in case of a Federal Government contract or subcontract, would be exempt from compliance with the Equal Opportunity Clause by 41 CFR S60-1.5. This section provides for the exemption of transactions not exceeding $10,000, contracts and subcontracts for indefinite quantities established not to exceed $10,000 in any contract year, contracts with certain educational institutions, work on or near Indian reservations, facilities (including, but not limited to, agencies, instrumentalities or subdivision of state or local government) which are separate and distinct from activities of the prime contractor or subcontractor related to the performance of the contract or subcontract, and emergencies involving national security.

_____ _____

Signature Date

_____

Name & Title of Signer

DRUG-FREE WORKPLACE FORM

The undersigned vendor in accordance with Florida Statute 287.087 hereby certifies that _____ does:
(Name of Business)

1. Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.

2. Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.

3. Give each employee engaged in providing the commodities or contractual services that are under bid a copy of the statement specified in subsection (1).

4. In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under bid, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of Chapter 1893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.

5. Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available in the employee's community, by any employee who is so convicted.

6. Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign the statement, I certify that this firm complies fully with the above requirements.

_____ _____
Bidder's Signature Date

Company:_____ Bid/RFP/PO:_____