



CITY OF BUCKEYE

**Request for Proposal
RFP NO. 2018008**

Group Insurance Benefits

Basic Life and Accidental Death & Dismemberment,
Voluntary Life and Accidental Death & Dismemberment,
Short Term Disability,
Fully Insured Medical, Voluntary Dental, Voluntary Vision,
Flexible Spending Account Administration, Cobra Administration, FMLA Administration,
And Employee Assistance Program

**CONTACT PERSON
Tyra Bell, Purchasing Agent
Construction and Contracting
623.349.6171
tbell@buckeyeaz.gov**

Issue Date:	November 9, 2018
Intent to Bid Due:	November 19, 2018, 5:00 P.M., M.S.T.
Last Date for Inquires:	November 20, 2018, 5:00 P.M., M.S.T.
Due Date:	December 10, 2018, 2:00 P.M., M.S.T.

PLEASE NOTE: IF RFP DOCUMENTS WERE DOWNLOADED FROM THE CITY OF BUCKEYE'S WEBSITE, CONTRACTOR IS RESPONSIBLE FOR OBTAINING ANY ADDENDA EITHER THROUGH UPDATES ON THE WEBSITE, OR BY CONTACTING THE CONTACT PERSON LISTED ABOVE.

I. INTRODUCTION

A. General Information

The City of Buckeye, Arizona is requesting sealed proposals from qualified contractors to provide Group Insurance Benefits.

Sealed Proposals will be received at the City Hall, 530 East Monroe Avenue, Buckeye, Arizona 85326, until 2:00 P.M., M.S.T., December 10, 2018 at which time a representative of the City will announce publicly the names of those contractors or individuals submitting proposals. No other public disclosure will be made until after award of the contract. Any proposal received after 2:00 P.M. on the above stated date will be returned unopened. The City anticipates selecting a firm and awarding a contract by March 2019.

During the evaluation process, the City of Buckeye reserves the right, where it may serve the City's best interest, to request additional information or clarifications from proposers. At the discretion of the City of Buckeye, firms submitting proposals may be requested to make oral presentations as part of the evaluation process.

B. Terms of Engagement

An initial one-year contract with the option of up to four (4) one year renewals is anticipated. Effective date July 1, 2019.

II. NATURE OF SERVICES

A. Background and Scope of Work

The City is seeking proposals from qualified vendors to provide fully insured contracts and plan administration, as follows:

- ✚ Basic Life and Accidental Death and Dismemberment
- ✚ Voluntary Life and Accidental Death and Dismemberment
- ✚ Short Term Disability
- ✚ Fully Insured Medical
- ✚ Voluntary Dental
- ✚ Voluntary Vision
- ✚ Flexible Spending Account Administration
- ✚ Cobra Administration
- ✚ FMLA Administration
- ✚ Employee Assistance Program

Due to HIPAA regulations, the census file and Financial Workbook have not been included in the RFP. Vendors should complete and sign the Confidentiality Agreement contained as Exhibit 1. The completed form should be emailed to Rachel Calisi at rcalisi@segalco.com. Upon receipt, the census and Financial Workbook will be sent via secure email from Segal Consulting, the City's Employee Benefit Consultant.

Plans shall be effective July 1, 2019.

B. UNDERWRITING INFORMATION

The City offers the benefits listed in this Request for Proposal to all eligible employees. Cigna has provided the City's medical program since July 1, 2009. Cigna has also provided the City's dental program since July 1, 2018. The dental program was previously offered through MetLife from July 1, 2014 – June 30, 2018. Vision benefits have been offered through Ameritas since July 1, 2014. The Employee Assistance Program is provided through MHN.

Since July 1, 2014, SunLife has provided the Basic and Voluntary Life and Accidental Death and Dismemberment (AD&D) and the Short-Term Disability (STD).

The Flexible Spending Account Administration has been provided by WageWorks since July 1, 2012. COBRA Administration is currently provided by Infnisource.

Please note that the City is currently implementing the Munis/Tyler system for their employee self-service enrollment system. The City expects that the system will not be fully operational until July 2019 or later.

All programs currently are and shall continue to be net of commissions. If any commissions are included (socialized or otherwise), you must clearly identify them in your proposal.

Eligibility

All active full time employees working a minimum of 30 hours per week are eligible for benefits coverage. In addition, certain coverage is offered to Elected Officials (Mayor, Vice Mayor, and Council Members). See specific line of coverage for more details on coverage offered to Elected Officials. Coverage begins the first day of the month following or coinciding with the date of hire.

Employees who elect coverage for themselves can enroll their eligible dependents for applicable coverage, including children up to age 26. Domestic partners are eligible for medical, voluntary dental, voluntary vision, voluntary life, and voluntary AD&D benefits only.

The City requires employees to complete and submit a paper enrollment form to the Human Resources Department. City staff then enters enrollment and changes online via the vendor's portal. All City employees and their dependents are eligible for the Employee Assistance Plan.

Census and Financial Exhibits

A census file and the Financial Workbook have not been included due to HIPAA regulations. Vendors should complete and sign the Confidentiality Agreement contained as Exhibit 1. The completed form should be emailed to Tyra Bell at tbell@buckeyeaz.gov. Upon receipt, the census and Financial Workbook will be sent via secure email from Segal Consulting, the City's Employee Benefit Consultant.

Plan Designs

The City plans to continue to offer the current plan designs July 1, 2019. Benefit Comparison Charts for each line of coverage can be found in Exhibits 10 thru 19. Vendors should complete the charts by describing the benefits that are being offered.

BASIC LIFE and AD&D and VOLUNTARY LIFE and AD&D

Classification

Basic Life and AD&D and Voluntary Life and AD&D include the following classifications:

Class I All active full time employees working a minimum of 30 hours per week.

Class II All active Elected Officials of the Employer classified as Mayor, Vice Mayor, and Council Member.

A copy of the Life and AD&D Policies are included as Attachments A.

Rate History

Below is a history of rates for the Basic Life and AD&D:

Basic Life and Basic AD&D		
	July 1, 2014- June 30, 2017	July 1, 2017- June 30, 2019
Basic Life (per \$1,000)	\$.11	\$.116
Basic AD&D (per \$1,000)	\$.02	\$.02

The Voluntary Life and AD&D coverage has a portability feature allowing former employees and dependents to continue coverage under the Group plan assuming they had coverage at the time of termination of employment.

The rate history for the Voluntary Life coverage is shown below.

Voluntary Life and AD&D Employee and Spouse July 1, 2014 – June 30, 2019		
	Non-Smoker	Smoker
Under Age 20	\$.04	\$.06
20 to 24	.07	.09
25 to 29	.07	.09
30 to 34	.07	.09
35 to 39	.08	.13
40 to 44	.11	.21
45 to 49	.16	.32
50 to 54	.26	.50
55 to 59	.42	.77
60 to 64	.66	1.10
65 to 69	1.16	1.68

Voluntary Life and AD&D Employee and Spouse July 1, 2014 – June 30, 2019		
	Non-Smoker	Smoker
70 to 74	2.21	3.15
75+	4.46	6.31
Child(ren)	\$.20 for \$1,000 per month. Maximum \$10,000.	
AD&D	\$.037 for \$1,000 per month.	

**Active Spouse and Domestic Partner coverage terminates at age 70.*

Experience

Paid premium, paid claims, enrollment, and volume of coverage reports for the life coverage are contained in the experience documents contained in Attachment Q.

The Insurance Experience report includes both Basic and Voluntary life and accident insurance coverage (as well as Short Term Disability). There have been no Waiver of Premium claimants.

Contributions

The City pays the cost of employee Basic Life and AD&D Insurance. Employees pay the cost of the Voluntary Life and AD&D coverage for themselves and their covered dependents.

The City remits premiums on a monthly basis from a list bill generated by SunLife.

Requirement:

The City wants to pay the monthly premium at the end of the month for which the premium is due.

Plan Design

It is the City's intent to continue to offer these same benefits effective July 1, 2019.

SHORT TERM DISABILITY

Classifications

The City's Short Term Disability plan includes the following classifications:

- Class I All active full time employees working a minimum of 30 hours per week.
- Class II All active Elected Officials of the Employer classified as Mayor, Vice Mayor, and Council Member.

A copy of the STD policy is included as Attachment A.

Rate History

Below is a history of the rates for the Short Term Disability Plan:

Short Term Disability Rate History Per \$10.00 of Weekly Benefit		
	July 1, 2014-June 30, 2017	July 1, 2017-June 30, 2019
Class I	\$.075	\$.116
Class II	\$.075	\$.116

Experience

Paid premium and claim experience reports have been included as Attachment Q.

Contributions

The City pays the full cost of Short Term Disability coverage for all eligible employees. The City remits premiums on a monthly basis from a list bill generated by SunLife.

Requirement:

The City wants to pay the monthly premium at the end of the month for which the premium is due.

Plan Design

The current plan design is contained in the Policy under Attachment A. There have not been any plan changes since the policy effective date. It is the City's intent to continue to offer the same level of coverage. Benefits under the STD plan integrate with all City provided time off.

FULLY INSURED MEDICAL

Plan Design

The City currently offers three plans to eligible employees and their dependents. A copy of the Summary Plan Description is included as Attachment D.

Rate History

Below is the history of rates for the past three years:

		OAP	HMO	HDHP*
Plan Year	Rate Tier	Monthly Rate	Monthly Rate	Monthly Rate
2018-2019	Employee	\$763.34	\$690.10	\$639.56
	Employee + Spouse	\$1,371.72	\$1,240.12	\$1,145.69
	Employee + Child(ren)	\$1,295.45	\$1,171.18	\$1,082.23
	Employee + Family	\$2,095.58	\$1,894.53	\$1,747.89
2017-2018	Employee	\$681.52	\$628.94	\$486.82
	Employee + Spouse	\$1,224.69	\$1,130.21	\$871.23
	Employee + Child(ren)	\$1,156.60	\$1,067.38	\$823.04
	Employee + Family	\$1,870.96	\$1,726.63	\$1,328.60

		OAP	HMO	HDHP*
Plan Year	Rate Tier	Monthly Rate	Monthly Rate	Monthly Rate
2016-2017	Employee	\$752.49	\$694.44	\$537.05
	Employee + Spouse	\$1,352.23	\$1,247.91	\$961.49
	Employee + Child(ren)	\$1,277.05	\$1,178.54	\$908.29
	Employee + Family	\$2,065.81	\$1,906.45	\$1,466.50

*Rates include \$4.50 PEPM charge for Health Savings Account

Effective July 1, 2016, the City added the HMO and the HDHP plans.

There were no plan changes made for the 2017-2018 Plan Year.

The OAP plan had the following plan changes effective July 1, 2018:

- ✚ Increased the in-network out-of-pocket maximum from \$1,500/\$3,000 to \$2,000/\$4,000 and the out-of-network out-of-pocket maximum from \$3,500/\$7,000 to \$4,000/\$8,000.
- ✚ Increased the Rx copays from \$10/\$20/\$40 to \$10/\$25/\$50.

The plan is underwritten on a fully insured, experience rated, non-participating basis with a \$150,000 pooling level.

Experience

Paid premium, paid claims, and enrollment history for the past two years is contained in Attachments I, J, and K. Each plan year report includes the monthly data for medical, dental, and vision.

A large claim report has also been included for the last several plan years as Attachments M, N and O, listing claims in excess of \$25,000.

Contributions

Below is a chart that outlines the City's contributions of the premium for Employee Only and Employee plus Family coverages for each medical plan. It is anticipated that this contribution strategy will continue July 1, 2019.

Contribution Strategy		
	Employee	Employee and Family
PPO	88%	84%
HMO	95%	91%
HDHP	100%	100%

The City remits premiums on a monthly basis from a list bill generated by Cigna.

Requirement:

The City wants to pay the monthly premium at the end of the month for which the premium is due.

VOLUNTARY DENTAL CARE

Plan Design

Eligible employees and their dependents can elect to participate in one of two Voluntary Dental Plans offered by the City. The City offers employees a choice between a High PPO Plan and a Low PPO Plan. The plans have been underwritten by Cigna since July 1, 2018. MetLife previously underwrote the plans from July 1, 2014-June 30, 2018. It is the intent of the City to continue to offer these two options July 1, 2019.

A complete description of the current plans is contained in Attachments E and F.

Rate History

Below is a history of rates for each plan for the past three years.

Plan Year	Rate Tier	High PPO	Low PPO
2018-2019	Employee	\$71.16	\$31.32
	Employee + Spouse	\$147.06	\$60.84
	Employee + Child(ren)	\$164.26	\$71.63
	Employee + Family	\$255.04	\$81.36
2017-2018	Employee	\$74.04	\$32.58
	Employee + Spouse	\$153.00	\$63.30
	Employee + Child(ren)	\$170.90	\$74.52
	Employee + Family	\$265.34	\$84.64
2016-2017	Employee	\$66.12	\$29.10
	Employee + Spouse	\$136.62	\$56.52
	Employee + Child(ren)	\$152.60	\$66.54
	Employee + Family	\$236.92	\$75.58

Experience

The High and Low PPO Plans are experience rated. Paid premium and claims experience reports for the past three years are contained in Attachments I, J, and K. Please note that the plan changed from a calendar year accumulation of deductibles and out-of-pocket maximums to a plan year basis effective July 1, 2018.

Contributions

Employees pay the full cost of the premiums for this coverage. The City remits premiums on a monthly basis from a list bill generated by Cigna.

Requirement:

The City wants to pay the monthly premium at the end of the month for which the premium is due.

VOLUNTARY VISION CARE

Plan Design

The City currently offers employees the option of participating in the Voluntary Vision plans that have been underwritten by Ameritas since July 1, 2014 on a non-experience rated basis. It is the City's intent to continue to offer the vision plans July 1, 2019. A copy of the current plans is contained in Attachments G and H.

Rate History

Below is the history of rates for the Vision plans:

Plan Year	Rate Tier	Monthly Premium
2014-2019	Employee	\$7.64
	Employee + Spouse	\$15.08
	Employee + Child(ren)	\$13.44
	Employee + Family	\$20.88

Experience

Paid premium, Paid claims, and enrollment reports for the past three years are contained in Attachments I, J, and K. Please note that the plan is based on date of service for purposes of tracking benefits and the City is interested in moving to a plan year benefit effective July 1, 2019.

Contributions

Employees contribute the full cost of the premiums for this coverage. The City remits premiums on a monthly basis from a list bill generated by Ameritas.

Requirement:

The City wants to pay the monthly premium at the end of the month for which the premium is due.

FLEXIBLE SPENDING ACCOUNT ADMINISTRATION

The City currently contracts with WageWorks to administer its Flexible Spending Account program. The plan has a \$2,550 Maximum Health Care Spending Account and a \$5,000 Dependent Care Spending Account. Eligible expenses must be incurred on a plan year basis, July 1 through June 30.

There are currently 224 employees who have a Health Care Reimbursement Account, 20 employees who have a Limited Purpose Reimbursement Account, and 15 employees who have a Dependent Care Reimbursement Account. There are 14 employees currently participating in both Dependent Care and Health Care accounts. The plan provides a debit card to the Health Care Reimbursement Account participants.

It is the intent of the City to continue to offer the FSA program to employees as of July 1, 2019.

COBRA ADMINISTRATION

The City currently contracts with Infinisouce to provide COBRA administration. On average, the City has 3 COBRA qualifying events per month. At the current time, there are three employees and three dependents on COBRA continuation coverage. The City plans to continue to contract with an outside vendor to provide COBRA administration as of July 1, 2019.

FMLA ADMINISTRATION

The City is interested in a vendor who can provide administration processes including FMLA notification/call intake, tracking, intermittent FMLA, case management, employee correspondence and reporting processes. The City is currently administering FMLA in-house.

The ideal FMLA administrator will provide legally compliant administration of FMLA with an emphasis on customer service, efficiency/accuracy in the tracking, record-keeping and management of FMLA leaves, appropriate depth of claim management, reduction of FMLA absences, aggressive identification and management of FMLA abuses and comprehensive reporting to management in an effort to assist the client with their absence reduction strategies.

The City wants a system that recognizes a varied work schedule not just 5 days a week, 8 hours a day (e.g. firefighters work 48 hours on and 96 hours off).

EMPLOYEE ASSISTANCE PROGRAM

Plan Design

The City currently sponsors an Employee Assistance Program that has been provided through MHN since July 1, 2014. The program was a 3-visit model until July 1, 2017 when it changed to a 6-visit model. The EAP is offered to all City employees, regardless of whether they are benefit eligible or not.

All City employees and their eligible dependent have access to the EAP benefits. The City pays the premium to MHN based on 645 employees. The census that is included in this RFP process lists only those employees who are benefit eligible as described in Section II B – Underwriting.

It is the City's intention to continue to offer EAP benefits to all City employees.

Rate History

The premium since July 1, 2017 has been \$1.71 per employee per month. From July 1, 2014 – June 30, 2017 the premium was \$1.59 per employee per month. The premium is billed by MHN directly to the City, who pays the entire cost.

Requirement:

The City wants to pay the monthly premium at the end of the month for which the premium is due.

Utilization

Attachment R includes EAP utilization reports.

III. General Requirement/Information

- A. All formal inquiries or requests for significant or material clarification or interpretation, or notification to the City of errors or omissions relating to this Request for Proposal must be directed, in writing to:

City of Buckeye
Tyra Bell, Purchasing Agent
530 East Monroe Ave.
Buckeye, Arizona 85326
tbell@buckeyeaz.gov
Tel: 623-349-6171

Requests must be submitted on a copy of the Inquiry Form included in **Exhibit 3** of this Request for **November 20, 2018**. Failure to submit inquiries by this deadline may result in the inquiry not being answered. Note that the City will answer informal questions orally. The City makes no warranty of any kind as to the correctness of any oral answers and uses this process solely to provide minor clarifications rapidly. Oral statements or instructions shall not constitute an amendment to this Request for Proposal. Contractor shall not rely on any verbal responses from the City. If you have formal questions about any part of this Request for Proposal, which could result in a material issue or a formal amendment to this Request for Proposal, submit your questions on the Inquiry Form from **Exhibit 3** of this Request for Proposal.

- B. Proposals should be submitted as a document set, containing **one (1) clearly marked original** and **eleven (11) additional copies (for a total of twelve (12) submitted) and one electronic copy on a flash drive**.
- C. Proposers should submit the completed Proposal to the following:

City of Buckeye
Tyra Bell, Purchasing Agent
530 East Monroe Ave.
Buckeye, Arizona 85326

Proposals shall be in a sealed envelope/box marked:

Name of Contractor: _____
Title of Proposal: **Group Insurance Benefits**
RFP Number: **RFP No. 2018008**

Proposals are due not later than **2:00 P.M., M.S.T., December 10, 2018**. No telephone, electronic or facsimile proposals will be considered. Proposals received after the time and date for closing will be returned to the Contractor unopened.

- D. You may withdraw your proposal at any time prior to the time and date set for closing. Proposals withdrawn after opening but prior to award, may be withdrawn in accordance with the City of Buckeye Procurement Code.
- E. No department or office at the City has the authority to solicit or receive official proposals other than the Construction and Contracting Division. All solicitations are performed under the direct supervision of the Construction and Contracting Manager, and in complete accordance with City of Buckeye Procurement Code.

- F.** The City reserves the right to conduct discussions with contractors, to accept revisions of proposals, and to negotiate price changes. During this discussion period, the City will not disclose any information derived from proposals submitted, or from discussions with other contractors. Once an award is made, the solicitation file, and the proposals contained therein, are in the public record and will be disclosed upon request.
- G.** Contractors submitting proposals which meet the selection criteria and which are deemed to be the most advantageous to the City may be requested to give an oral presentation to a selection committee. The Purchasing Agent will perform scheduling of these oral presentations.
- H.** The award shall be made to the responsible contractor whose proposal is determined to be the most advantageous to the City based on the evaluation factors set forth in this Request for Proposal. Price, although a consideration, will not be the sole determining factor.
- I.** The Arizona Public Records Act limits the City's ability to withhold prequalification and bid data. If a proposal contains any trade secrets that a contractor does not want disclosed to the public or used by the City for any purpose other than evaluation of the contractor's eligibility, each sheet of such information must be marked with the designation "Confidential." The City agrees that if a "Public Records Act" request is made for disclosure of data so classified, it will notify the contractor submitting the proposal of such data so that the contractor will have an opportunity to legally challenge the City's obligation to disclose such information.
- J.** Your proposal should be submitted in the format shown in Section V. Proposals in any other format will be considered informal and may be rejected. Conditional proposals will not be considered. An individual authorized to extend a formal proposal must sign all proposals. Proposals that are not signed may be rejected.
- K.** The City reserves the right to reject any or all proposals or any part thereof, or to accept any proposal, or any part thereof, or to withhold the award and to waive or decline to waive irregularities in any proposal when it determines that it is in its best interest to do so. The City also reserves the right to hold all proposals for a period of 120 days after the opening date.
- L.** May: Indicates something that is not mandatory but permissible/desirable.
 Shall, Must, Will: Indicates mandatory requirement. Failure to meet these mandatory requirements will result in rejection of your proposal as nonresponsive.
 Should: Indicates something that is recommended but not mandatory. If the contractor fails to provide recommended information, the City may, at its sole option, ask the contractor to provide the information or evaluate the proposal without the information.
- M.** Any person, contractor, corporation or association submitting a proposal shall be deemed to have read and understood all the terms, conditions, and requirements in the specifications/scope of work.
- N.** All responses and accompanying documentation will become the property of the City at the time the proposals are opened.
- O.** The City shall not reimburse any contractor the cost of responding to a Request for Proposal.
- P.** The City believes that it can best maintain its reputation for treating all contractor and suppliers in a fair, honest, and consistent manner by conducting solicitations in good faith and by granting contractor an equal opportunity to win an award. If you feel that we have fallen short of these goals, you may submit a protest pursuant to the Procurement Code of the City of Buckeye.

IV. EVALUATION PROCEDURES

A. Method of Selection

Vendors should provide their quotes on a free standing basis for each line of coverage as multiple awards may be considered. In addition, vendors are encouraged to provide a packaged approach **if there is a cost savings associated with bundling of any services, but in no event must your offer be contingent on all coverages.** The City will award the contract based on the evaluation factors set forth in this Request for Proposal.

All proposals must be submitted via the proposal process. Any proposals received outside of the proposal process will be disqualified.

B. Oral Interview/Proposal Presentations

Based upon its review of the proposal submittals, the City may select, in its sole discretion, a short list of firms who best meet the City's objectives. Firms on the short list may be invited to participate in the Interview/Presentation phase of the process. Proposers submitting proposals which meet the selection criteria and which are deemed to be the most advantageous to the City may be requested to give an oral presentation to a selection committee. The Purchasing Agent will perform scheduling of these oral presentations.

C. Negotiations

The City will offer the most advantageous contractor a thirty (30) day exclusive negotiation period. In the event that there is an impasse in the negotiations, the City reserves the right to go to the next most advantageous contractor, the City reserves the right to reject all proposals at any time.

V. EVALUATION CRITERIA

In accordance with the City's Procurement Code, awards shall be made to the responsible Contractor whose Proposal is determined in writing to be the most advantageous to the City, based upon the evaluation.

A. Qualifications and experience of contractor (35 points)

1. Financial position of insurance company, managed care organization, financial institution or third party administrator.
2. Qualifications of the vendor to provide the City with the services requested in the Scope of Work.
3. Personal experience and history with a firm by any member of the selection committee.
4. Vendor's ability to show a history of demonstrated competences.

B. Understanding of the Services (30 points)

1. Responsiveness of the proposal in clearly stating and understanding the scope of work, and meeting the requirements of the RFP including matching the requested plan design and meeting the contractual requirements.
2. The City's assessment of the vendor's abilities to meet and satisfy the needs of the City, taking into consideration proposed services or expertise offered that exceed the requirements, or the vendor's inability to meet some of the requirement of the specifications.
3. Ability to provide excellent administrative support and member services to the City and its covered employees and dependents.
4. Medical, Dental, and Vision Network size and disruption.
5. Reporting capabilities
6. Performance Guarantees
7. Compliance with applicable State and Federal laws and regulations.

C. Cost (30 points)

1. Premium rates, retention costs, administration fees and renewal underwriting procedures.
2. Renewal rate guarantees.

D. References (5 points)

1. Information obtained by the City from vendor's references or other Cities.

Total points possible = **100**

V. PROPOSAL FORM

To facilitate direct comparisons, your proposal shall be submitted in the following format, listed in order, and index tabbed to match. The City requests that you limit your proposal responses and material to only the information necessary to understand the services you are proposing. Additional marketing material beyond those requested in this solicitation are discouraged. If contractor fails to provide any of the requested information, with the exception of the mandatory proposal certification, the City may, at its' sole option, ask the contractor to provide the missing information or evaluate the proposal without the missing information.

A. Request for Proposal Contents

Your hard copy proposal should conform to the following format:

- | | |
|-----------|---|
| Section 1 | Cover letter with an original ink signature by a person authorized to represent this proposal shall be submitted with Contractor's original proposal, with one (1) reprographic copy in each subsequent copy of the proposal. (Maximum one (1) pages.) |
| Section 2 | Financial Workbook* <ul style="list-style-type: none">• Vendor Information Form (Excel)*• Fee Quotation Forms (Excel)* |
| Section 3 | Questionnaire Responses (Word)* |
| Section 4 | Performance Guarantees (Word)* and Geo Access Report (PDF) |
| Section 5 | Specimen Contracts
Satisfaction Survey Results (most recent) |
| Section 6 | All Forms Contained in the Vendor Exhibit Section of this Document <u>except the Plan Design Comparison Charts which should be submitted in Word</u> * |
| Section 7 | Miscellaneous (lengthy question responses, underwriting caveats, and any other materials necessary to understand the services you are proposing).

Sample Standard Reporting Package (premium billing invoice, monthly accounting report, sample EOB).

Sample Renewal Underwriting Package |

***These completed exhibits must be included in your proposal on a flash drive. The documents must be in their native format where noted (Word or Excel) and NOT PDF.**

Note: Failure to respond to all requested information may be considered non-responsive and may disqualify a proposal from further consideration.

B. QUESTIONNAIRE (Please see Exhibit 2)

Questionnaire instructions to Vendors:

*****DO NOT ALTER THE QUESTIONS OR QUESTION NUMBERING*****

1. Provide answers to the questionnaires in MS Word format.
2. Provide an answer to each question even if the answer is “not applicable ”or “unknown.”
3. Answer the question as directly as possible.
 - a. If the questions asks “How many...” provide a number
 - b. If the question asks, “Do you...” indicate Yes or No **first**, followed by your additional narrative explanation.
4. Lengthy responses may be truncated when displayed...to avoid this, be concise in your response. Use bullet points as appropriate. **Reconsider how to word any response that exceeds 200 words in length so that the response contains the most important points you want displayed.** Refer the reader to an appendix/attachment for further information.
5. Where you desire to provide additional information to assist the reader in more fully understanding a response, refer the reader of your RFP response to your appendix/attachments.
6. RFP responses will become part of the contract between the winning Vendor and the City.
7. All references to “City” in the questionnaire refer to The City of Buckeye.

NOTE: Answers to the questions must be provided in hard copy and MS Word format on Flash Drive.

DO NOT PDF or otherwise protect the Flash Drive.

ALL VENDORS MUST COMPLETE THE QUESTIONS THAT ARE APPLICABLE TO THE COVERAGE BEING PROPOSED

EXHIBITS

Exhibit 1	Confidentiality Agreement
Exhibit 2	Questionnaire
Exhibit 3	Inquire Form
Exhibit 4	Offer and Acceptance
Exhibit 5	Non-Collusion Affidavit
Exhibit 6	Deviations and Exceptions
Exhibit 7	Proposal Certification/Conflict of Interest Certification
Exhibit 8	Past and Pending Lawsuits
Exhibit 9	Intent to Propose
Exhibit 10	PPO Plan Design Comparison Chart
Exhibit 11	HDHP Plan Design Comparison Chart
Exhibit 12	HMO Plan Design Comparison Chart
Exhibit 13	DPPO High Plan Design Comparison Chart
Exhibit 14	DPPO Low Plan Design Comparison Chart
Exhibit 15	Dental Plan Limitations Chart
Exhibit 16	Vision Plan Design Comparison Chart – Option 1
Exhibit 17	Vision Plan Design Comparison Chart – Option 2
Exhibit 18	Basic Life and AD&D Plan Design Comparison Chart
Exhibit 19	Voluntary Life and AD&D Plan Design Comparison Chart
Exhibit 20	Accidental Death & Dismemberment (Basic and Voluntary) Plan Provisions
Exhibit 21	Short Term Disability Plan Design Comparison Chart

Exhibit 1
Confidentiality Agreement
to Be Used by Entities
Responding to the RFP Issued by Segal Consulting

Date: _____

Name: _____

Job Title: _____

Company Name: _____

Business Address: _____

THIS CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT is between **The Segal Group, Inc.**, on behalf itself and its operating subsidiaries and affiliates, including Segal Consulting, (“Segal”) and _____

_____, on behalf of itself and all of its subsidiaries and affiliates, (“Bidder”) and is executed in connection with various bids, proposals or other replies (each a “Bid”) that Bidder intends to submit to Segal in response to various Request For Proposals/Requests for Information (each an “RFP”) issued by Segal on behalf of one or more of Segal’s clients (each a “Client”).

WHEREAS, in order to prepare its Bid, Bidder needs to receive certain plan information and data, which may include individually identifiable health information pertaining to a Client health plan participants and beneficiaries, (“Client Health Plan Information”) and certain Segal proprietary information consisting of the RFP questionnaire and specifications and any associated financial spreadsheets (the Client Health Plan Information, together with the other Segal proprietary information are collectively referred to as “Segal’s Proprietary Information”). For the avoidance of doubt, the term “individually identifiable health information” refers to any health information, including demographic information, that is not “de-identified,” as defined in 45 C.F.R. Section 164.514(b)(2);

WHEREAS, in order to evaluate Bidder’s Bid, Segal and Client may need to receive certain proprietary information from Bidder which may include, but not be limited to, provider-specific network allowances and reimbursement arrangements and other information designated by Bidder in writing as confidential and proprietary information of Bidder (“Bidder’s Proprietary Information”); and

WHEREAS, Segal’s Proprietary Information and Bidder’s Proprietary Information are collectively referred to as “Proprietary Information.”

NOW THEREFORE, in order to exchange Proprietary Information in connection with the RFP, the parties agree as follows:

1. Bidder will use Segal’s Proprietary Information only for the purpose of preparing its Bid and as otherwise permitted by paragraph 5 of this Agreement. Segal will use Bidder’s Proprietary Information only for the purpose of evaluating Bidder’s Bid and as otherwise permitted by paragraph 5 of this Agreement.
2. Bidder and Segal agree that only those individuals employed by them who have a need to know Proprietary Information to prepare or evaluate the Bid and have been made aware of the terms of this Agreement and agreed to abide by its terms will have access to Proprietary Information of the other party (“Bidder’s Representatives” and “Segal’s Representatives”).

3. Neither Bidder nor any Bidder Representatives will disclose Segal's Proprietary Information to any person or entity outside of Bidder, unless such a disclosure is: (a) necessary to prepare the Bid and the recipient first executes a confidentiality agreement with provisions no less stringent than this one; or (b) required by law. Neither Segal nor any Segal Representatives will disclose Bidder's Proprietary Information to any person or entity outside of Segal (other than Client), unless such a disclosure is: (a) necessary to evaluate the Bid and the recipient first executes a confidentiality agreement with provisions equivalent to this one; or (b) required by law.
4. Bidder and Segal agree to use commercially reasonable efforts to maintain the security of the Proprietary Information of the other party.
5. Each party will return the other party's Proprietary Information to the other party or destroy it upon completion of the RFP process if such return or destruction is feasible, except that Segal may retain an archival copy of Bidder's Proprietary Information for its file. If Bidder determines that return or destruction of some or all of Segal's Proprietary Information is not feasible, Bidder agrees to: (a) inform Segal, in writing, of the specific reason(s) that make return or destruction not feasible; (b) extend the protections of this Agreement to any retained information for as long as Bidder retains it; and (c) limit further uses or disclosures to those that make the return or destruction infeasible.
6. Bidder will report to Segal, in writing, any use and/or disclosure of individually identifiable health information that is not permitted by this Agreement.
7. Each party shall regard and preserve as confidential all of the other party's Proprietary Information that has been or may be obtained by such party during the course of the RFP, whether Bidder or Segal has such information in memory, or in writing or in other physical form. Neither party shall, without written authority from the other party, use for such party's benefit or purposes, either during the RFP process or thereafter, any Proprietary Information of the other party, except as necessary to respond to the RFP or evaluate the RFP response.
8. With respect to the RFP and the Proprietary Information exchanged in connection therewith, the obligations assumed by the parties in this Agreement shall continue beyond completion of the RFP process.
9. In certain instances, Segal may conduct the RFP process electronically through the use of a third party hosted Website. The host Website being used is owned by Proposal Technologies Network, Inc. ("Proposal Tech"). Proposal Tech and Segal have entered into a confidentiality agreement that protects the confidentiality of Segal's and Bidder's Proprietary Information, as well as Client's confidential information.
10. Bidder shall and does hereby agree to indemnify, defend and hold harmless Segal, Client and their respective officers, directors, employees and shareholders from and against any and all claims, demands, losses, costs, expenses, obligations, liabilities, damages, recoveries, and deficiencies, including interest, penalties, and reasonable attorney fees and costs, that the other may incur or suffer and that result from, or are related to, any breach or failure of Bidder or Bidder's Representatives to perform any of the representations, warranties and agreements contained in this Agreement that pertain to individually identifiable health information.
11. Each party recognizes that any breach of the covenants contained in this Agreement would irreparably injure the other party and/or Client. Accordingly, the non-breaching party may, in addition to pursuing its other remedies, obtain an injunction from any court having jurisdiction of the matter restraining any further violation and no bond or other security shall be required in connection with such injunction.
12. If any of the provisions herein become invalid or are declared invalid, such determination of invalidity as to the clause(s) shall not affect the other provisions of this Agreement. If any provision of this Agreement should be held invalid or unenforceable, the remaining provisions shall be unaffected by such a holding. If any provision is found inapplicable to any person or circumstance, it shall nevertheless remain applicable to all other persons and circumstances.

13. This Agreement shall be binding upon Segal and Bidder and their respective successors, assigns, heirs, executors and administrators.
14. This Agreement contains the entire understanding of the parties hereto and supersedes all previous communications, representations, or agreements, oral or written, with respect to the subject matter hereof. No failure to exercise nor any delays in exercising any right or remedy hereunder shall operate as a waiver thereof; nor shall any single or partial exercise of any right or remedy hereunder preclude any other or further exercise thereof or the exercise of any other right or remedy. Neither this Agreement nor any of its provisions may be amended, supplemented, changed, waived or rescinded except by a written instrument signed by the party against whom enforcement thereof is sought. No waiver of any right or remedy hereunder on any one occasion shall extend to any subsequent or other matter.
15. This Agreement shall be governed by and construed in accordance with the laws of the State of New York applicable to contracts made on and performed within the State of New York.
16. The written notices required by paragraphs 5 and 6 of this Agreement shall be sent by certified mail, return receipt requested, postage prepaid or by overnight air express mail service to: General Counsel, The Segal Group, Inc., 333 West 34th Street, New York, New York 10001.

Intending to be legally bound, the parties have executed this Agreement.

THE SEGAL GROUP, INC.

BIDDER

Signed: _____

Signed: _____

Name: _____

Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

**EXHIBIT 2
QUESTIONNAIRE**

NOTE: Answers to the questions must be provided in hard copy and MS Word format on Flash Drive.

DO NOT PDF or otherwise protect the Flash Drive.

ALL VENDORS MUST COMPLETE THE QUESTIONS THAT ARE APPLICABLE TO THE COVERAGE BEING PROPOSED

Complete this form and include it with your response. Vendor will be held accountable for the accuracy and validity of all answers.

**MINIMUM CONTRACTUAL REQUIREMENTS
ALL VENDORS**

Indicate “Yes” or “No” as to your organization’s ability to meet the minimum requirements. **Failure to complete this form and include it with your response may result in elimination from consideration.**

A “Yes” response shall result in the provision being adopted in the final contract. No deviations will be accepted for “YES” answers in this section.

MINIMUM CONTRACTUAL REQUIREMENTS (ALL PROPOSERS)	YES	NO
1. Proposal, Interview, and Best and Final Responses Become Part of Contract: Do you agree that your written response to this RFP, written information provided as part of an interview and written responses provided during a Best and Final negotiation become part of the contract between your organization and the City of Buckeye?		
2. Effective Date of Offer: Bid terms are guaranteed for at least 150 days from the proposal due date.		
3. You agree that the Contract has a length of one (1) year with the option to renew for four (4) additional one year periods.		
4. Rates/Fees are guaranteed for a minimum of 12 months.		
5. Variance Provision: Do you have any provisions relating to reevaluation of proposed rates due to variation in enrollment or other contingencies of the quote? Explain below.		
6. Proper Licensure: Do you agree to maintain proper licensure as required by any state law where it relates to the services that you will be performing for the City of Buckeye?		
7. Prior Notice of Major Operational Changes: Do you agree to provide no less than 30 day notice to the City of Buckeye for any changes involving the sale, merger, data breaches, layoffs, participating provider facility terminations, consolidation or outsourcing of services to foreign workers that will impact the City of Buckeye?		

MINIMUM CONTRACTUAL REQUIREMENTS (ALL PROPOSERS)	YES	NO
<p>8. Subcontracting: Unless otherwise explained in this RFP, do you agree that you will disclose all subcontractor arrangements, and any additional fees associated with the subcontractor arrangements, that involve the services provided to the City of Buckeye?</p>		
<p>9. Mutual Indemnification: Do you agree that the contract will contain a mutual indemnification/hold harmless provision?</p>		
<p>10. HIPAA Compliance: Vendor attests to meeting all applicable HIPAA EDI, Privacy, Security, and HITECH requirements and agrees to hold the City of Buckeye harmless for breaches that are the result of the vendor's actions. Further, you agree to perform all of the duties associated with breach notification and assume financial responsibilities for the breach notice and notify plan participants if there is a breach and you will pay for 24 months of identity theft repair and credit monitoring services for those plan participants impacted by the breach.</p>		
<p>11. Eligibility Rules and Uncertain Claimant Eligibility Situations: The vendor agrees to the specified eligibility rules established by the City of Buckeye. The vendor(s) must communicate directly with the City of Buckeye regarding any uncertain claimant eligibility situations before notifying the claimant of ineligibility.</p>		
<p>12. Eligibility Rules and Procedures for Retroactive Termination and Reconciliation: The vendor agrees to the specified eligibility rules established by the City of Buckeye. Upon receipt of a retroactive termination, the vendor must review the applicable patient histories and initiate recovery efforts for any overpayments resulting from the late termination notice.</p>		
<p>13. No Member Communication Without City Consent: The vendor will not automatically enroll the City of Buckeye in any programs that involve any type of communication with members, without express written consent from the City of Buckeye.</p>		
<p>14. Claims and Appeals Regulations: Do you agree that your systems, internal operations, correspondence, and services will be compliant with ERISA Claims and Appeals Regulations (as applicable) and the City's plan document?</p>		
<p>15. Rights to Claims Data: All member claim records are the sole property of the City of Buckeye. Selling of the City's data to outside entities must be disclosed and approved in writing in advance by the City of Buckeye. All claims data obtained during the contract period and for up to seven years after the contract termination is the property of the City of Buckeye and must be available upon request.</p>		
<p>16. On-Line Historical Data: Maintain at least seven years of the City of Buckeye's claims data (all fields indicated on the billing) and eligibility information at all times.</p>		

MINIMUM CONTRACTUAL REQUIREMENTS (ALL PROPOSERS)	YES	NO
<p>17. Once each year, or more frequently as reasonably determined by Client, or within two (2) years following termination of this Agreement, Client's third party Auditor(s) ("Auditor"), as reasonably approved by Vendor (which approval shall not be unreasonably withheld), may inspect and verify claim data, eligibility, billing records, pricing discounts and terms, claims adjudication systems, healthcare benefits, clinical programs, subcontracted administrative services directly related to Client's Member utilization and services, performance guarantees, and operational processes relating to the services provided to Client pursuant to this Agreement to ensure Vendor's compliance with the terms and conditions of this Agreement, as Client deems appropriate.</p>		
<p>18. Bidder agrees to grant the right of the City of Buckeye or its representative(s) to audit claims at any time during and up to two years following termination of the business relationship with prior written notification. The City of Buckeye will have access to 100% of all valid claim records to complete the audit at no cost to the plan sponsor. Bidder agrees to provide all necessary claims details, data definitions and reasonable support to complete an independent claim audit for each completed year under the contract in effect. The City of Buckeye will not be held responsible for time or miscellaneous costs incurred by the bidder in association with an audit including, but not limited to, the costs associated with providing audit reports, systems access, or onsite space.</p>		
<p>19. Such audits may be based on either a 100% review of claims or a statistically representative sample thereof, or combination of methodologies. Auditor's preliminary findings will be shared with Vendor. Any findings from a statistically representative sample of claims will be extrapolated to the total claims population for purposes of measuring overall financial dollar and incidence processing achievements; Vendor will produce financial impact reports for confirmed systemic errors. In the instance where Auditor has reviewed 100% of claims and identified suspect claims, Vendor may elect to review a mutually-agreed upon representative sample of the suspect claims.</p>		
<p>20. The audit may include an onsite review of the sample claims by the Auditor at Vendor's office. The Auditor will provide Vendor with the sample claims thirty (30) calendar days in advance of the onsite review. The onsite review will last up to five (5) business days.</p>		
<p>21. The scope of such audits may include up to three (3) benefit plan years as determined by Client.</p>		
<p>22. Any and all costs and expenses of each party associated with Client's audit shall be borne by the party incurring the cost. The parties agree that the scope of audits by Client or Auditor will not be duplicative of the SSAE-18 audit, but may include inspection and/or verification of certain information provided in the SSAE-18 audits to the extent necessary to give a more thorough understanding of and support for such information. Audit materials or documentation provided by Vendor will be confined to client-specific information.</p>		
<p>23. If the audit discovers any validated overpayment of fees or claim payments by Vendor or other errors that result in economic losses to the client for failure to meet all vendor guarantees or performance standards, then Vendor shall pay the amount owed to the Client following completion of the audit, within 30 days of written confirmation from the client as to the agreed upon settlement terms and amounts.</p>		

MINIMUM CONTRACTUAL REQUIREMENTS (ALL PROPOSERS)	YES	NO
<p>24. Recoveries: 100% of all validated recoveries made through the vendor, its subcontractors, or the City of Buckeye's audits will be credited to the City of Buckeye's experience.</p>		
<p>25. Maintenance, Ownership, and Transfer of Records:</p> <ul style="list-style-type: none"> a. The vendor will be required to maintain all pertinent records for seven years. This is in conjunction with prudent business practice and (as applicable) ERISA provisions; and b. The vendor will be charged with the safekeeping of plan experience information; and c. In the event of contract termination, and related to contract termination, the vendor will be required to cooperate with the City of Buckeye, or their representative, in the prompt, accurate, and orderly transfer of the City of Buckeye's plan experience, claims and utilization information to City of Buckeye or its designated succeeding health plan/carrier at no added fee. 		
<p>26. Termination Provisions: The City of Buckeye may terminate the contract at any time after the first complete plan year without cause, by giving 90 days' written notice. The City of Buckeye can terminate with cause with 30 days' notice unless proper remedy is provided by the vendor. The vendor may only terminate for cause with proper legal minimum notice requirements.</p>		
<p>27. Renewal Notification: The vendor must provide any rate changes in writing with full justification by February 1 of the prior plan year for a July 1 effective date. Additionally, the vendor must provide the following with each renewal package:</p> <ul style="list-style-type: none"> a. Any contract language changes requested b. Specific justification of rate/fee changes c. Current enrollment by rate class d. Additional options for consideration e. All underwriting caveats f. Any proposed plan design or benefit changes 		
<p>28. Assignment or Transfer of Rights: Do you agree that you will not assign or transfer the rights or obligations of the contract or any portion thereof, without the prior written approval of the City of Buckeye?</p>		
<p>29. Pended Claims: Make available, upon request, reports regarding the number and nature of claims pended, if your organization is processing the claims.</p>		
<p>30. Commissions: a) Is your proposal submitted net of commissions? b) If commissions are built into your rates and cannot be stripped out of them will you pay them to the District's consultant, the Segal Group?</p>		
<p>31. Both the Basic Life insurance and the Voluntary Life insurance contracts include a waiver of premium provision applicable to disabilities that commence prior to age 60. The contracts should assume terminal liability for all claims incurred under the waiver provision.</p>		
<p>32. Your STD proposal does not require that employees exhaust their sick leave prior to receiving benefits.</p>		

MINIMUM CONTRACTUAL REQUIREMENTS (ALL PROPOSERS)		YES	NO
33. Your STD proposal assumes that all coverage is Guarantee Issue.			
34. Do you agree to provide local Account Management (Arizona based) throughout the term of this contract (not including FSA or COBRA Administration)?			
If you answered "No" to any of the questions above, please provide an explanation below:			
Requirement No.	Explanation		

<p style="text-align: center;">CONTRACTUAL</p> <p>If your response varies based on line of coverage, please clearly indicate</p>	<p style="text-align: center;">Indicate Confirmation: Yes or No</p>	<p style="text-align: center;">Explain any "No" response</p>
<p>1. Renewal Notification: The successful bidder must provide any fee change in writing, including full justification, on or before 150 days prior to each contract anniversary.</p>		
<p>2. Termination Provisions: The City may terminate the contract at any time by giving 30 days written notice. The successful bidder may only terminate the contract by giving notice 120 days in advance. The City can terminate the contract without cause or financial penalty at any time during the duration of the contract.</p>		
<p>3. Size Variance Provision: Any provisions, references, or guidelines relating to reevaluation of proposed fees/rates due to variation in enrollment in the plan must not be less than 15% of the enrollment at the beginning of each plan year.</p>		
<p>4. Subcontracting:</p> <p>a. List any services related to the Scope of Work of this RFP that you currently subcontract (or plan to subcontract for this contract) and the name of the vendor(s) to whom you subcontract.</p> <p>b. Unless otherwise explained in this RFP, do you agree that you will not subcontract for any services related to the Scope of Work, without advanced notice to the City?</p> <p>c. Do you agree subcontractors are used in the delivery of services under this proposal your firm is responsible for the timeliness, accuracy, privacy, reporting, and comprehensiveness of the subcontractor's services?</p>		

CONTRACTUAL If your response varies based on line of coverage, please clearly indicate	Indicate Confirmation: Yes or No	Explain any "No" response
d. Explain any of your current contractual relationships with a third-party firm in which the third party firm will be paid by the City either directly or indirectly during the course of the contract with the City (e.g. % of savings).		
5. Do you agree that the City can pay the premium invoices at the end of the month for which the premium is due?		
6. Do you agree that you will not assign or transfer the rights or obligations of the contract or any portion thereof, without advanced notice to the City?		
7. Do you agree to maintain proper licensure as required by any state law where it relates to the services that you will be performing for the City?		
8. Do you agree that your contract includes an indemnification/hold harmless clause to protect the City?		
9. HIPAA Compliance: All bidder systems and services must comply with the HIPAA EDI, Privacy, and Security regulations at all times. Do you agree to maintain adherence to federal HIPAA Privacy and Security regulations as it relates to the personal health information you receive about the City's plan participants during the proposal, implementation, contract, and post-contract periods?		
10. Are you willing to sign a contract with the City that indicates your firm will pay fines the City may be assessed as a result of your firm's noncompliance with HIPAA EDI, Privacy and Security regulations and pay costs associated with remedy of any breach your firm initiates?		

GENERAL INFORMATION	VENDOR RESPONSE If your response varies based on line of coverage, please clearly indicate	
1. Indicate your firm's most recent ratings by all of the following agencies: A.M. Best Standard and Poor's (S&P) Fitch Moody's Weiss	Month and Year of Rating	
	Rating	Date
2. Organization background: a. Organization's name. b. Corporate headquarters address. c. City & State that will service the City's account. d. Does your firm have a local office? e. Date your firm became operational. f. Date your firm became operational for the services requested in this RFP. g. Ownership of your firm.		
3. Implementation: a. What is the minimum implementation lead-time needed to initiate the proposed services? b. List any transition issues the City should consider. c. List any specific administrative procedures or information your firm will need from The City in order to implement your services?		
4. Complete the following information about the individual who will be assigned as the OVERALL ACCOUNT MANAGER for the City: Name & Title: City/State: Length of Time in Current Position:		

GENERAL INFORMATION	VENDOR RESPONSE If your response varies based on line of coverage, please clearly indicate
<p>5. Complete the following information about the individual from your organization who will be assigned as the PRIMARY DAY TO DAY CONTACT for the City:</p> <p>Name & Title:</p> <p>City/State:</p> <p>Length of Time in Current Position:</p>	
<p>6. Identify any services under any subsequent contract that may be awarded as part of this RFP that are currently or planned to be performed outside the borders of the United States.</p>	
<p>7. Do you agree to attend the Annual Open Enrollment meeting at the City's desired location (normally one meeting on one day at one location) at no additional cost?</p>	
<p>8. As the City does not expect their employee self-service enrollment system to be up and running until July 2019 or later, how can you firm assist the City with open enrollment?</p>	
<p>9. Will your firm accept paper enrollment forms at open enrollment? If so, you will provide assistance to the City to load the enrollment information into whatever spreadsheet or platform is required in order to upload enrollment data?</p>	
<p>10. If you do not accept paper enrollment forms, what other resource do you have for the City to provide enrollment information?</p>	
<p>11. Do you agree to provide the City a clear path (representative phone number or email, etc.) for employees to register complaints?</p>	
<p>12. If you are proposing Medical, are you willing to provide a medical plan RFP process allowance of at least \$7,500 to be paid to the City, payable upon execution of your contract?</p>	
<p>13. If you are proposing Dental, are you willing to provide a dental plan RFP process allowance of at least \$5,000 to be paid to the City, payable upon execution of your contract?</p>	
<p>14. If you are proposing Vision, are you willing to provide a vision plan RFP process allowance of at least \$2,500 to be paid to the City, payable upon execution of your contract?</p>	

GENERAL INFORMATION	VENDOR RESPONSE If your response varies based on line of coverage, please clearly indicate
<p>15. Review the current plan documents for each line of coverage you are proposing and confirm that your proposed plan exactly matches the current plan. If your proposed plan does not exactly matches, provide the list of deviations on the Deviations Form and indicate which line of coverage it is for.</p>	

CUSTOMER SERVICE OPERATIONS	VENDOR RESPONSE If your response differs by line of coverage you are proposing, provide your response for each line
1. Will there be a designated team of customer service representatives for the City? <ul style="list-style-type: none"> a. Will you provide a toll-free customer service number for claim and benefit inquiries? b. Are questions regarding provider billing, benefits, or member grievances covered by the same phone number? c. If not, please explain. 	
2. What hours and days are live customer service representatives available (indicate using AZ time)?	
3. Are your customer service representatives in the continental US?	
4. What alternative services do you provide? (i.e., Assistance for the hearing impaired, 24-hour toll-free automated benefits and eligibility, customer service accessible via the internet, etc.)	
5. Please provide the following statistics for 2016 and 2017: <ul style="list-style-type: none"> a. Average speed to answer: ___% within 30 seconds b. Busy rate: ___ seconds c. Abandonment Rate : ___% 	
6. Will the City have online access to address additions, terminations, and status changes?	
7. Are plan participants able to access a web portal for: <ul style="list-style-type: none"> a. Status of claims? b. Benefit brochure? c. ID cards? 	
8. Can the City and their designated Consultant access eligibility and reporting through a secure website?	
9. What kind of reports can the City retrieve online?	

<p style="text-align: center;">CUSTOMER SERVICE OPERATIONS</p>	<p style="text-align: center;">VENDOR RESPONSE</p> <p style="text-align: center;">If your response differs by line of coverage you are proposing, provide your response for each line</p>
<p>10. What other kinds of information can the City obtain through your website?</p>	
<p>11. What kind of web tools do you have for consumer engagement such as:</p> <ul style="list-style-type: none"> a. Network provider quality b. Treatment estimator c. Deductible/out-of-pocket accumulator d. Modeling of plan options for members? 	
<p>12. Please provide a temporary login/password so the City can evaluate your tools.</p>	
<p>13. How long before notification of a new employee is the additional charge reflected on your premium billing?</p>	
<p>14. Does your firm provide both paper and electronic billing and reports?</p>	
<p>15. How are billing discrepancies reconciled?</p>	
<p>16. What methods does your organization use to measure customer satisfaction?</p>	
<p>17. Provide a copy of your most recent customer satisfaction survey statistics.</p>	

BASIC LIFE & AD&D	VENDOR RESPONSE
1. a. Does your contract include a conversion option? b. What is your charge per thousand to the policyholder for life insurance conversions?	
2. Do you offer portability for Basic Life?	
3. Will all existing plan participants be grandfathered into your plan with their existing Basic Life coverage levels? If not, please explain what will happen at takeover.	
4. a. Do you agree to provide the same coverage for currently insured individuals without requiring evidence of insurability? b. If not, what amount of coverage can be provided without evidence of insurability?	
5. Please describe your actively at work provision on takeover. What happens if someone is out because they are: a. on vacation; b. in the hospital; c. on a medical leave of absence?	
6. Describe any Accelerated Death Benefit provision contained in your policy.	
7. Does your contract provide terminal liability for waiver of premium claims upon termination of your master contract?	
8. Do you offer waiver of premium for Basic Life?	
9. a. Does your contract include a waiting period for Wavier of Premium? b. If so, how long is the waiting period?	
10. If you have a waiting period for wavier of premium and an employee is subsequently approved, are premiums waived back to the initial date of disability or only from the approval date of the waiver?	
11. If an employee is approved for waiver of premium, are dependent premiums waived also?	
12. When, if ever, does your Wavier of Premium provision terminate?	
13. What is your definition of Total Disability?	

BASIC LIFE & AD&D	VENDOR RESPONSE
14. a. At the first renewal (depending on how long you guarantee rates), how much credibility would be applied to the City's specific experience if enrollment remains as provided on the census?	
b. How much would this change by at the subsequent renewal?	
15. a. How are waiver of premium claims reserved (percent of premium or claims)?	
b. What percentage is used?	
16. Do you agree to provide your underwriting analysis as back up for any future renewals?	
17. What retention percent was used in your rate development?	
18. Do you agree to provide monthly paid premium, paid claims, enrollment, volumes insured, and premium waiver claims?	

VOLUNTARY LIFE AND AD&D	VENDOR RESPONSE
1. a. Does your contract include a conversion option? b. What is your charge per thousand to the policyholder for Voluntary life insurance conversions?	
2. Do you offer portability for: a. Voluntary Employee Life b. Voluntary Employee Life c. Voluntary Child life	
3. Will all existing plan participants be grandfathered into your plan with their existing Voluntary Employee, Spouse, and Dependent coverage levels? If not, please explain what will happen at takeover for each.	
4. Does your proposal require that an employee elect employee Voluntary life before electing to cover their dependents (i.e., spouse only coverage)?	
5. a. Do you agree to provide the same coverage for current insureds without requiring evidence of insurability? b. If not, what amount of coverage can be provided without evidence of insurability?	
6. Do you have a minimum participation level for the voluntary coverages? If so, what is it?	
7. Is the current participation in the voluntary life sufficient for you to offer coverage?	
8. What minimum participation requirement would be reflected in your contract?	
9. What happens if the minimum participation falls below the level stated in the contract (re-rate, termination)?	
10. How much can participation vary before you would require a re-rate?	
11. What participation requirements are assumed in your proposal given what has been provided in the census?	

VOLUNTARY LIFE AND AD&D	VENDOR RESPONSE
<p>12. a. Describe how the City is notified when a participant needs to submit evidence of insurability.</p> <p>b. How will the City be notified of a participant's approval or denial of submitted evidence of insurability?</p> <p>c. Are the costs for evidence of insurability health exams included in your rates?</p>	
<p>13. Do you offer waiver of premium for:</p> <p>a. Voluntary Employee Life</p> <p>b. Voluntary Spouse Life</p> <p>c. Voluntary Child Life</p>	
<p>14. Does your policy include an accelerated death benefit?</p>	
<p>15. Does your contract provide terminal liability for waiver of premium claims upon master contract termination?</p>	
<p>16. Does your contract require that participants be active-at-work on the effective date of your contract?</p>	
<p>17. Please describe your actively at work provision on takeover. What happens if someone is out because they are:</p> <p>a. on vacation;</p> <p>b. in the hospital;</p> <p>c. on a medical leave of absence?</p>	
<p>18. Is this policy portable (i.e., can the employee retain the same coverage at essentially the same rate if he/she leave employment)?</p>	
<p>19. How do the rates for terminated employees who port coverage compared to active employees?</p>	
<p>20. Are there any restrictions on being able to port coverage (i.e., disabled, plan maximums, etc.)?</p>	
<p>21. Does your organization have the ability to administer the portability and conversion recordkeeping?</p>	
<p>22. If your policy is not portable, what is the impact to your rates to include this provision?</p>	

VOLUNTARY LIFE AND AD&D	VENDOR RESPONSE
23. If the master contract terminates, do you continue to provide coverage to terminated employees who ported coverage under your contract?	
24. Describe any pre-existing condition limitations included in your proposal.	
25. At what point in the year is the City required to change the premium for participants who move into a new age bracket? (i.e., January 1, the renewal date, monthly)?	
26. What retention percentage was used to develop your proposed rates?	
27. Do you agree to provide monthly paid premium, paid claims, enrollment, volume insured, and waiver of premium claims?	
28. a. At the first renewal (depending on how long you guarantee rates), how much credibility would be applied to the City's specific experience if enrollment remains as provided on the census? b. How much would this change by at the subsequent renewal?	
29. a. How are waiver of premium claims reserved (percent of premium or claims)? b. What percentage is used?	
30. What additional services, if any, are included in your Voluntary Life & ADD contract (e.g., funeral planning, concierge services, EAP, etc.)	

SHORT-TERM DISABILITY (STD)	VENDOR RESPONSE
1. If you were awarded the Life and AD&D and Short-Term Disability Plan together, are there any additional financial savings or rate guarantees you could provide? If so, please explain.	
2. Please describe your actively at work provision on takeover. What happens if someone is out because they are a. on vacation; b. in the hospital; c. on a medical leave of absence?	
3. a. Does your proposal include the payment of the employer FICA taxes? b. Provisions of the W-2 reporting?	
4. a. Does your company's contract include integration with any other benefit? b. If yes, outline those contract provisions.	
5. a. Does your STD contract contain any exclusion for alcoholism, psychiatric treatment, or drug abuse? b. If yes, outline the specific exclusions that apply.	
6. a. How often will you verify the disability status of a claimant? b. How do you verify if an individual qualifies for disability payments? c. How are the results of the re-evaluation reported back to the City? d. How do you handle a case where the participant no longer meets the clinical criteria for a condition?	
7. Will you guarantee that all insureds who would have continued to be covered on the plan effective date if there had been no change in carriers will be covered by your policy on the plan effective date?	
8. What is the guarantee issue level (if any) in the proposed plan?	

SHORT-TERM DISABILITY (STD)	VENDOR RESPONSE
9. a. Does your policy have any restrictions for pre-existing conditions? b. Are there actively-at-work provisions in your policy? c. Do you agree to waive this provision for current insured's are covered on the effective date, but not at work (i.e., teachers, vacations, etc.)?	
10. What retention percent was assumed in the development of your rate?	

MEDICAL CLAIM ADMINISTRATION SERVICES	VENDOR RESPONSE
1. From what location would this policyholder's claims be processed?	
2. What is your company's claims processing turn-around time for medical claims not involving coordination of benefits?	
3. Does your claim system have any protections against fraud by: a. Providers b. Members c. Employees	
4. How do you determine and define R&C for non-network medical benefits (e.g., own data, percentile of FAIR Health, relative value scale)?	
5. How often is R & C data updated?	
6. What percent of Medicare will non-network claims be paid?	
7. Does your claim system have any protections against unbundling and/or upgrading claims? If so, describe in detail.	
8. When you are COB secondary payor, do you use your UCR profiles or those of the primary carrier to determine your level of reimbursement?	
9. How long does your firm process run-out claims after contract termination?	

MEDICAL NETWORK	VENDOR RESPONSE
1. Indicate the marketing name of the network you are proposing.	
<p>2. Please provide Geo Access reports using the following access standards:</p> <p>Your results must be based on those employees on the census that have currently elected medical benefits (433 employees).</p> <p>Reports should reflect city, state, zip code, and number of unique providers by zip, number of employees with desired access (as defined below) for each category AND locations (Zip Code and County) where access standards are not met including the number of employees without desired access.</p> <p>a. Primary Care Provider:</p> <p>Access criteria: 2 providers within 10 miles of home zip code</p> <p>b. Specialists:</p> <p>Access criteria: 1 provider within 10 miles of home zip code</p> <p>c. Hospitals:</p> <p>Access criteria: 2 providers within 20 miles of home zip code</p>	
3. Confirm that Cancer Treatment Centers of America is in your proposed network.	
<p>4. For 2016 and 2017, provide the number of network participating providers that were terminated in the City's service area:</p> <p>a. By your organization</p> <p>b. By the provider</p>	
5. What changes do you anticipate to your network over the next two years?	
6. How is continuity of care maintained if the City were to change to your network?	
7. What percent of your providers are open to new patients?	
8. What types of providers are typically not under a contract with your network (anesthesiologists, radiologists, pathologists, emergency room physicians, etc.)?	

MEDICAL NETWORK	VENDOR RESPONSE
9. What discount off billed charges was realized by your enrolled members in Maricopa County during 2017?	
10. How does your organization measure the quality of care provided by the providers in your network?	
11. How many complaints per 1,000 visits do you receive on your network providers?	
12. List all clinical programs your proposal requires the City to participate in (i.e., mandatory generic, prior authorization, step-therapy (list drugs), mandatory mail order, etc.).	
13. a. Is prescription drug coverage provided through your network or a separate PBM? b. If a separate PBM, state the name of the PBM.	
14. Under your prescription drug benefit, will the member pay the lowest of the following: Plan copay, plan discounted price and dispensing fee, U&C, or retail cash?	

FULLY-INSURED MEDICAL UNDERWRITING	Vendor Response
1. Does your proposal reflect a contract with a \$150,000 medical pooling level?	
2. What credibility factor was assigned to the City's experience?	
3. What retention percent was used to develop your proposed rates?	
4. What experience period will be used for the first renewal (e.g., first 5 months)? What period will be used in second and later renewals?	
5. How much would the group have to change in size before the credibility percentages above would vary by more than 10 percent?	
6. Is retention calculated as a percentage of claims, percentage of premium, or on a per capita basis?	
7. a. Explain the methodology and data to be used for the renewal process.	
b. How will projected incurred claims be estimated for these plans?	
8. What credibility do you anticipate assigning to the City's experience at: First Renewal?	
Subsequent?	
9. What is your current leverage trend factor for the pooling point proposed by your firm?	
10. What was your 2018 trend factor for the PPO network proposed?	
11. What is your anticipated trend factor for the product proposed and in the City's service area?	
12. Indicate your standard reserve factors you would use to get from paid to incurred for:	
Medical?	
Rx?	
13. What maturity factor would you use to adjust paid claims for the first renewal for:	
Medical?	
Rx?	

FULLY-INSURED MEDICAL UNDERWRITING	Vendor Response
14. What is your current leverage trend factor for the pooling point proposed by your firm?	
15. Do you agree to provide your underwriting calculations as the basis for any proposed rate changes?	
16. What is the pooling charge for the proposed pooling level in your premium rates?	
17. Do you agree to provide monthly paid premium, paid claims, enrollment, and large claims detail as part of your renewal?	

FULLY-INSURED MEDICAL GENERAL	VENDOR RESPONSE
1. Are you able to match the current medical benefits exactly ?	
2. If not, have you listed all deviations on the Deviations and Exceptions Exhibit contained in this RFP. (Do not refer to any other document to respond to this question.)	
3. Will the City have online access to make additions, terminations, and status changes?	
4. List the type of providers who have Contracts based on capitation.	
5. If your firm uses capitation, is the charge to the City the amount you pay to the providers (in other words, do you keep a spread)?	
6. How will your Patient Centered Medical Home or ACO impact or be included in your PPO network proposed?	

HDHP/HSA ADMINISTRATIVE SERVICES	VENDOR RESPONSE
1. What is the name of the HSA administrator (i.e. the Medical TPA, a contracted partner)?	
2. Explain the basis for your qualifications as an HSA administrator and the dates of qualification.	
3. How long have you provided HSA administration services?	
4. What information or administration services for HSA's are available on your website?	
5. Do you have a call center available to answer questions telephonically?	
6. Name the qualified HSA custodians/ trustees (e.g. banks and insurers) with which you have a relationship and describe that relationship.	
7. What services and reporting can the City and its employees expect from the HSA custodian/trustee?	
8. Explain the payroll and transfer of funds process from the employer to the bank.	
9. Are there any charges to the City or its members outside the proposed premium rates?	

DISEASE MANAGEMENT	VENDOR RESPONSE
1. Have you included information in your response regarding all of the Disease Management Programs that you are offering to the City?	
2. Did you propose your Disease Management Program as an Opt-Out approach, as requested?	
3. Are you willing to include performance guarantees based on the effectiveness of your Disease Management Program?	

MEDICAL PLAN REPORTING						
Report Type	Month	Quarter	Annual	Vendor Response (Y or N)	Online Access (Y or N)	Excel (Y or N)
Premiums Paid						
Enrollment by coverage tier	X					
Paid Claims						
➤ By Type (fee for service, capitated), Rx	X					
➤ By Status (Active, COBRA)	X					
De-Identified Large Claim Report - \$25,000 with diagnosis						
➤ By Status (Active, COBRA, terminated)	X					
Other Claims Reports						
➤ Claims Lag			X			
Network Utilization						
➤ In-Network			X			
➤ Out-of-network			X			
➤ Out-of-State			X			
Utilization (benchmark) Reports to the City in October each year			X			
Ad Hoc Reporting Capabilities						
➤ Ability for the City to generate Ad Hoc Reports	Determined by the City					
➤ Does the information provided allow drill down on the data?						

DPPO BENEFIT ADMINISTRATION	VENDOR RESPONSE
<p>1. As an Attachment to your response: Provide a complete description of the benefit limitations and exclusions which your company proposes to make a part of the dental program. (Be specific about any provision that could be construed as pre-existing condition limitations. Be sure your description differentiates between pre-existing dental conditions for which dental treatment commenced prior to the effective date and those for which treatment has not commenced.)</p>	
<p>2. a. Does your proposed plan include any exclusions or limitations that are more restrictive than the current plans?</p> <p>b. Does your proposal include any pre-existing condition limitations?</p> <p>c. If so, list any exclusions and/or limitations. Do not refer the reader to your proposal but specifically detail in Exhibit 4, Deviations, and Exceptions.</p>	
<p>3. Describe how treatment in progress (at initial takeover) will be covered. How will orthodontic claims be adjudicated? What portion of claim expenses will be honored?</p>	
<p>4. Describe how treatment in progress will be covered if your plan is terminated during an episode of treatment. What services (i.e., root canal, crowns, etc.) are covered and for what amounts?</p>	
<p>5. What additional benefits do you offer to pregnant women?</p>	
<p>6. Are medications covered under the dental plan?</p>	
<p>7. Do discounts apply to members after the annual maximum has been reached?</p>	
<p>8. How will your plan pay benefits for students or other dependents who reside outside of the State of Arizona?</p>	
<p>9. Describe how your pretreatment review system operates.</p>	
<p>10. Provide a description of those circumstances under which benefits continue being paid upon:</p> <p>a. termination of an insured's coverage;</p> <p>b. termination of the policy.</p>	
<p>11. Do you agree to an annual open enrollment at which time you would waive pre-existing limitations?</p>	

DPPO CLAIM ADMINISTRATION SERVICES	VENDOR RESPONSE
1. From what location would this policyholder's claims be processed?	
2. What is your company's claims processing turn-around time for dental claims not involving coordination of benefits?	
3. Does your claim system have any protections against fraud by: a. Providers b. Members c. Employees	
4. With respect to network claims: a. Are any authorization forms necessary or ID cards required? b. Do members pay up-front and submit claims for reimbursement or are members responsible for only plan copays, deductibles, and coinsurance? c. If paper claim submission is required, what is the turn-around time for a member's claim to be processed (date of receipt to date check is issued)? d. Are there any time limits for submitting claims?	
5. How do you determine and define R&C for non-network dental benefits (e.g., own data, percentile of Fair Health, relative value scale, NDAS)?	
6. Explain how maximum allowable charges are determined geographically: a. By the location of the employer, or the provider of dental services? Other? Please explain. b. How are specific areas delineated (e.g., 5 digit zip, 3 digit zip, county)?	
7. How often is data updated?	
8. What steps are taken if the maximum allowable charge is uncoded? How are the City and plan participants supported in their resistance to charges in excess of allowances?	
9. Can a claimant find out what the maximum allowable charge is for a particular procedure in advance of having the procedure performed? If so, how?	

DPPO CLAIM ADMINISTRATION SERVICES	VENDOR RESPONSE
10. With respect to dental surgery, do you ever reimburse assistant surgeons? What is the basis for such a determination and how is the allowance for the assistant surgeon, if any, calculated?	
11. Does your claim system have any protections against unbundling and/or upgrading claims? If so, describe in detail.	
12. When you are COB secondary payor, do you use your UCR profiles or those of the primary carrier to determine your level of reimbursement?	
13. Does your proposed plan cover implants?	
14. Describe how your plan handles a request for a resin composite filling in posterior teeth.	
15. Does your plan use maximum allowable cost for limiting non-network allowances?	
16. What percent of Fair Health is your non-network allowance for zip codes: a. 853? b. 850? c. 852?	

DPPO PLAN UNDERWRITING	VENDOR RESPONSE
1. What experience period will be used for the first renewal (e.g., first 5 months)? What period will be used in second and later renewals?	
2. How much would the group have to change in size before the credibility percentages above would vary by more than 10 percent?	
3. a. Explain the methodology and data to be used for the renewal process. b. How will projected incurred claims be estimated for these plans?	
4. What credibility do you anticipate assigning to the City's experience at: First Renewal? Subsequent?	
5. What is your standard reserve factor (as a % of mature paid claims)?	
6. What maturity factor would you use to adjust paid claims for the first renewal?	
7. What is your historical DPPO pricing trend and anticipated 2018 pricing trend for your proposed plan in the greater Phoenix metropolitan area?	
8. Is retention calculated as a percentage of claims, a percentage of premium, or a per capita basis?	
9. Do you agree to provide detailed underwriting analysis to support any proposed change in premium rates?	
10. Confirm that you will provide an example of your renewal underwriting analysis as an attachment in Section 7 of your proposal.	
11. Do you agree to provide monthly paid claims and enrollment by plan option?	
12. What retention percentage was used to develop your proposed rates?	

DPPO NETWORK	VENDOR RESPONSE
1. Do you wholly own and operate the network you are proposing for the City?	
2. Indicate the marketing name of the network you are proposing.	
<p>3. Please provide Geo Access reports the following access standards:</p> <p>Your results must be based on those employees on the census that have currently elected dental benefits (374 employees).</p> <p>Reports should reflect city, state, zip code, and number of unique dental providers by zip, number of employees with desired access (as defined below) for each category AND locations (Zip Code and County) where access standards are not met including the number of employees without desired access.</p> <p>a. General Dentists: Access criteria: 2 providers within 10 miles of home zip code</p> <p>b. Specialists (excl. orthodontists): Access criteria: 2 providers within 10 miles of home zip code</p> <p>c. Orthodontists: Access criteria: 2 providers within 15 miles of home zip code</p>	
<p>4. For 2017, provide the number of network participating providers that were terminated in the City's service area:</p> <p>a. By your organization</p>	
<p>b. By the provider</p>	
5. What changes do you anticipate to your network over the next two years?	
6. How does your organization measure the quality of care provided by the providers in your network?	
7. How many complaints per 1,000 visits do you receive on your network providers?	
8. Do any network providers include night or weekend hours?	
9. In 2017 and for the City's service area, what were the average number of days between a request for non-emergency appointment and the actual visit for the network you are proposing?	
10. Do network providers pay a membership fee to your organization?	

DPPO NETWORK	VENDOR RESPONSE
11. How is emergency care handled for individuals traveling outside the service area?	
12. What coverage is offered to dependents who reside outside the service area?	
13. How is continuity of care maintained if the City were to change to your network?	
14. What percent of providers are open to new patients?	
15. Does your network require referrals to specialists?	
16. What discount off billed charges was realized by your enrolled members in Maricopa County in 2017?	
17. Does your plan include coverage for prescription drugs?	

DENTAL PLAN REPORTING						
Report Type	Month	Quarter	Annual	Vendor Response (Y or N)	Online Access (Y or N)	Excel (Y or N)
Paid Premiums	X					
Enrollment by plan, by coverage tier	X					
Paid Claims						
➤ By Type (Preventive, Basic, Major, Orthodontia)	X					
➤ By Status (Active, COBRA)	X					
Network Utilization						
➤ In-Network			X			
➤ Out-of-network			X			
➤ Out-of-State			X			
Utilization (benchmark) Reports to the City in October each year			X			
Ad Hoc Reporting Capabilities						
➤ Ability for the City to generate Ad Hoc Reports	Determined by the City					
➤ Does the information provided allow drill down on the data?						

VISION NETWORK	VENDOR RESPONSE
1. Do you wholly own and operate the network you are proposing for the City?	
2. Indicate the marketing name of the network you are proposing.	
3. Please provide a list of names and addresses for providers located in Buckeye.	
4. Please provide a list of your providers in the following three zip codes: 850, 852, and 853.	
5. Have you noted on the Deviations Form any provisions of the current benefit plan that you are not able to administer?	
6. Is your vision care network in the City's service area made up of retail chains only, independent opticians / ophthalmologists only, or a mixture of both?	
7. What percent of the offices are private provider offices versus chain stores?	
8. a. Does your organization have an association with any optical chain stores?	
b. If so, please specify and explain.	
<p>9. Please provide Geo Access reports using the following access standards:</p> <p>Your results must be based on those employees on the census that have currently elected vision benefits (326).</p> <p>Reports should reflect city, state, zip code, and number of unique vision providers by zip, number of employees with desired access (as defined below) for each category AND locations (Zip Code and County) where access standards are not met including the number of employees without desired access.</p> <p>a. Ophthalmologists:</p> <p>1 provider within 10 miles of home zip code</p> <p>b. Optometrists:</p> <p>1 provider within 10 miles of home zip code</p>	
10. For 2017, provide the number of network participating providers that were terminated in the City's service area:	
a. By your organization	
b. By the provider	
11. What changes do you anticipate to your network over the next two years?	

VISION NETWORK	VENDOR RESPONSE
12. How does your organization measure the quality of care provided by the providers in your network?	
13. How many complaints per 1,000 visits do you receive on your network providers?	
14. Do any network providers include night or weekend hours?	
15. How long is the average wait time to get an eye exam?	
16. Do network providers pay a membership fee to your organization?	
17. Do you provide services through Walmart?	
18. Do you provide services through Costco?	
19. Do you provide services through Sam's Club?	
20. Do you provide services through Target?	
21. How do your providers recognize a patient as a participant in your vision program - voucher, ID card, electronic connection to your eligibility database, etc.? Please explain.	
22. Does your proposal assume acceptance of the current participation level?	

VISION PLAN REPORTING						
Report Type	Month	Quarter	Annual	Vendor Response (Y or N)	Online Access (Y or N)	Excel (Y or N)
Paid Premium	X					
Enrollment by coverage tier	X					
Paid Claims						
➤ By Type (exams, frames, other materials)	X					
➤ By Status (Active, COBRA)	X					
Network Utilization						
➤ In-Network	X					
➤ Out-of-network	X					
➤ Out-of-State	X					
Utilization (benchmark) Reports to the City in October each year			X			
Ad Hoc Reporting Capabilities						
➤ Ability for the City to generate Ad Hoc Reports	Determined by the City					
➤ Does the information provided allow drill down on the data?						

EAP GENERAL INFORMATION	VENDOR RESPONSE
1. Confirm that your proposed plan matches the current plan of 6-visits.	
2. Does your firm have the capability to provide the additional resources as required by Arizona House Bill 2502 (see Attachment L)? If so, is there additional cost and what is that cost?	
3. Do you have the ability to maintain an eligibility database for pre-certification of services?	
4. Are you able to provide 24-hour telephonic access, seven days a week, to crisis mental health and substance abuse triage and counseling by trained, licensed professionals, with all calls logged?	
5. Do you agree that participants will have access to qualified counselors within these guidelines: urgent=same day, elective=within 5 working days?	
6. Do you agree to provide quarterly and annual utilization statistics, to include the following data on your EAP program: a. Total number of contacts each quarter. b. Number of contacts by type (e.g., walk-in, phone call, etc.) c. Number of contacts by enrollee status (e.g., employee, spouse, and child). d. Source of contact (e.g., self, supervisor, doctor, family member, etc.) e. Number of contacts by Primary presenting problem (e.g., stress, depression, alcohol, suicidal, marital, etc.) f. Contact type (first contact with EAP, previous contact). g. Contact gender (male, female). h. Contact age (in age band groupings such as, less than 18, 19-25, 26-35, 36-50, 51-64, 65 and older).	
7. It is important that continuity of care be maintained. Please describe how you will handle transition issues with respect to moving EAP services from the current vendor to your firm.	
8. Do you perform an Annual Patient Satisfaction Survey? (Y/N) If so, please provide the following information: a. Number of surveys distributed. b. Number of survey results received.	

EAP GENERAL INFORMATION	VENDOR RESPONSE
<p>c. At what point do you survey the individual?</p> <p>d. Will you provide City-specific survey results (if a statistically valid sampling is collected)?</p>	
<p>9. What is the average duration (in minutes) of your EAP's:</p> <p>a. Intake call?</p> <p>b. One-on-one EAP Counseling visit?</p> <p>c. Family therapy visit?</p> <p>d. Group therapy session?</p>	
<p>10. What are your standard business hours and days of operation?</p>	
<p>11. What are your "after" hours and days of operation?</p>	
<p>12. For your EAP counseling staff, what are your requirements for education (M.S., LCSW, etc.) and years of clinical experience?</p>	
<p>13. What percent of your EAP counselors/ therapists are at a Master's level?</p>	
<p>14. What level of employee answers the phone when a member calls (i.e., a receptionist with no clinical background, a counselor with a clinical background, MSW, etc.)?</p>	
<p>15. Indicate the qualifications of the staff that interact with the individual from initial phone call or walk-in, including triage and actual EAP counseling.</p>	
<p>16. What percent of your operational staff (e.g., intake coordinators and counselors) have been with your firm for more than one year?</p>	
<p>17. What are the total number of employees in your firm:</p> <p>a. Today</p> <p>b. One year ago</p>	
<p>18. Is your EAP program accredited by the Employee Assistance Society of North America (EASNA) and does it follow the guidelines of the Employee Assistance Professionals Association (EAPA)?</p>	
<p>19. How do you assist a member access your services (e.g. they call you and you give them names of providers to contact, you make the appointment for them, etc.). Please describe the member experience in 5-7 sentences.</p>	

EAP NETWORK PROVIDER CAPABILITIES	VENDOR RESPONSE
1. Discuss any significant changes in the size or location of your network in the next year, which would affect the City's population.	
2. Please provide a count of the number of unique providers available for one-on-one counseling consultations in: 850: 852: 853:	
3. Please provide a list of names and addresses for providers located in Buckeye.	
4. Indicate the type(s) of providers that currently have contracts with your network: a. Physicians, counselors, all mental health and substance abuse specialties except. b. Mental health/substance abuse hospital(s). c. Other ancillary providers (describe).	
3. What type of cases or specialized treatment conditions cannot be provided by the hospitals in your network (i.e., anorexia, bulimia, severe psychosis, commitment)?	
4. Where can these services be provided?	
5. Based on your most recent 12 months of experience with your current City base for whom you provide EAP Services, provide the following information related to referrals: a. Total number of referrals. b. Number and type of referral (e.g., answered questions only, refer for self-help, refer to EAP counseling, refer to PPO provider, refer to inpatient confinement, etc.). c. Reason for referral (need provider outside our expertise, exhausted number of EAP visits, etc.).	
6. What is the anticipated percent of enrollees who upon initial EAP evaluation need referral to a source other than your EAP counselors?	
7. What are the behavioral health (mental or substance abuse) diagnoses which your EAP program does not handle and necessitate referral outside your EAP program (e.g. psychiatrist medication management).	

EAP NETWORK PROVIDER CAPABILITIES	VENDOR RESPONSE
8. What factors determine whether your EAP will proceed with EAP counseling under the EAP benefit versus referring to the City's medical program?	
9. Will dedicated case workers and counselors be assigned to this account? If so, how many case workers/counselors will you assign?	
10. In what situations will a counselor or provider provide onsite assistance to patients at the emergency department or other locations? a. Is this service included in your basic fees? b. If not, please outline any fees.	
11. Based on your most recent 12 months of experience with your current City base for whom you provide EAP Services, provide the following information related to the services you are proposing: a. Total number of patients counseled. b. Total number of EAP visits. c. Average number of EAP visits per patient. d. Number of visits by counseling type (e.g., depression, marital discord, alcohol/sub abuse, etc.).	
12. How long has your firm been providing EAP services?	
13. Indicate the extent of your EAP service capabilities (within the city only, state, a few states, national, or international).	
14. Indicate your ability to provide a contract with a hold-harmless provision that relieves the City of any liability resulting from actions by your staff.	
15. Indicate any services for which your firm subcontracts.	
16. Indicate if the following communication materials will be provided to the City: a. Table Tents b. Newsletters c. Payroll Stuffers d. Other	<p style="text-align: center;">Yes/No (if additional cost, identify amount)</p>

FLEXIBLE SPENDING ACCOUNT (FSA) ADMINISTRATION	VENDOR RESPONSE
1. How much lead-time will be required for implementation? Please provide an implementation schedule.	
2. How often are reimbursements made to participants for the: a. Health FSA account b. DCAP account	
3. How much of an initial deposit/pre-funding of an account is required, if any?	
4. List the most common alternatives you administer for terminated employees who have an underspent account.	
5. How do you handle overpayments and underpayments ?	
6. Outline any performance guarantees you are willing to offer along with suggested penalty for non-performance.	
7. Do you agree to provide monthly management reports to the employer?	
8. What reports are available electronically	
9. Provide responses to the following questions regarding electronic payments (debit cards): a. What types of claims cannot be administered via your debit card? b. What debit card transactions would prompt a request for claim substantiation? c. What happens when an ineligible item is charged along with a covered prescription at the point-of-sale? d. How long does it take to deliver a debit card to a participant once you receive an enrollment form (in calendar days)?	
10. List the top five complaints you receive about debit card transactions.	

FLEXIBLE SPENDING ACCOUNT	YES	NO
1. Is the cost of communication materials included in your regular fee for the use of the program?		
2. Are customized communications available?		
3. Is the following information is available on your FSA website :		
a. Account balance/status information		
b. Download reimbursement forms		
c. List of reimbursable HCRA expenses		
d. List of reimbursable DCAP expenses		
e. Frequently asked questions (FAQ)		
f. Worksheets/calculators to determine appropriate contributions		
g. Quarterly account balance statements		
h. Year end balance reminder		
4. Do you have a method for tracking termination dates?		
5. Which methods are available for reimbursement requests:		
a. Mail		
b. Walk-in		
c. Fax		
d. E-mail (with scanned attachment)		
6. Do you offer online enrollment :		
a. For the employer?		
b. For the employee?		
7. Do you require the employer to maintain their own banking account and you write checks from that account?		
8. Is your proposal based on the assumption that checks/statements are mailed directly to the participant's address?		
9. Do you maintain an internal audit program verifying claims are properly adjudicated?		
10. Do you have a process to minimize an employee overspending their HCRA or DCAP account in a given year?		
11. Which of the following non-discrimination tests do you perform each year:		
a. Health FSA: Eligibility test		
b. Health FSA: Benefits test		
c. DCAP: Eligibility test		
d. DCAP: Contributions and Benefits test		
e. DCAP: More than 5% owners concentration test		
f. DCAP: 55% average benefits test		

FLEXIBLE SPENDING ACCOUNT	YES	NO
12. Do you agree to accept responsibility for an error made by your company that could result in the entire plan being disqualified under Section 125?		
13. Do you require the employer to provide you access to its employees to promote the sale of voluntary insurance products ?		
14. Must all participants use the debit card or can it be offered as an option?		
15. Is the use of the debit card limited to merchants with merchant category codes (MCC)?		
16. Will you accept hard copy claim submissions by those participants who forget to use their card?		
17. Do you agree to maintain IRS auditable recordkeeping for the City's Flex plan administration including the debit card program for at least 6 years?		
18. Do you have a method to avoid duplicate payment when a claim is submitted via debit card and the employee later submits a paper claim for the same expense?		
19. Do employees have a direct phone line to contact a customer service representative with issues?		
20. Have you administered a claim that has been investigated by the IRS for lack of substantiation or other compliance concerns?		

COBRA ADMINISTRATION	YES	NO
1. Are the following services included in your contract: <ul style="list-style-type: none"> a. Election Notice/Enrollment Applications? b. Coupon mailing/billing statement (identify frequency of mailing)? c. Premium Collection? d. Notice of Termination? e. Monthly Reporting to the City? f. Weekly Paid-Thru Reporting to Vendor? g. Submission of Premium Payments to Vendors? h. ACH Deductions of Premiums? i. Mailing of Rate Change Letters and annual Open Enrollment election notification? j. Termination of continuation coverage letters? k. Conversion notices (if applicable) at end of COBRA continuation coverage period? l. COBRA eligibility lists to other insurance company systems? m. Quarterly reports demonstrating whether your organization has met the performance standards submitted with your proposal as required? 		
2. Will you provide an 800 number for participants?		
3. Is there an additional cost for the number? (detail on fee sheet)		
4. Do you currently have City clients for whom you coordinate with ASRS?		
5. Does your proposal include a copy of the participant satisfaction survey you use regarding feedback on your COBRA administration performance?		

COBRA ADMINISTRATION	VENDOR RESPONSE
1. What kinds of reports are available?	
2. Describe in detail the frequency and process you use to notify respective vendors that premiums have been received to avoid the vendor holding up processing of claims until premium is paid (<i>i.e.</i> , weekly vendor paid thru reports).	
3. Describe your annual Open Enrollment implementation process. How do you notify current continuants and individuals in a pending COBRA election status?	
4. What are the top five complaints you receive about COBRA transactions?	
5. What has been your telephone average speed to answer for the location you propose would handle this employer's business?	
a. 2016 average speed in seconds	
b. 2017 average speed in seconds	
6. What has been your average telephone abandonment rate for the location you propose would handle this City's business.	
a. 2016 abandonment rate	
b. 2017 year-to-date abandonment rate	

FMLA ADMINISTRATION		YES	NO
1.	Do you understand that the City reserves the right to schedule an FMLA Administration audit of your services by their own staff or their designee, as they deem appropriate?		
2.	Does your phone system record 2-way conversations?		
3.	Can you take an employee absence call 24 hours a day 7 days a week including holidays?		
4.	If you receive absence calls that are unrelated to FMLA, can you promptly route the caller or information to the appropriate client location for further management?		
5.	Can you coordinate information with other administration vendors the client may use or internal client departments, such as for sick leave, STD, LTD, workers' compensation, employee benefits staff or payroll?		
6.	Do you foresee any problems in FMLA administration for the City's population?		
7.	Do you report on the duration of leave requested vs. the leave authorized?		
8.	Can you track patterns of FMLA abuse and report this to the City for their evaluation?		
9.	Do you provide reports on the number and type of leave requests that are denied?		
10.	Do you have a fully integrated system that allows self-serve for employees, managers and Human Resources?		
If you answered "No" to any of the questions above, please provide an explanation below:			
Question No.	Explanation		

FMLA ADMINISTRATION	VENDOR RESPONSE
1. Besides FMLA administration, what other absence management administration services do you offer, such as jury leave, military leave, bereavement leave, etc.	
2. How does your FMLA administration process coordinate with other leaves that the City may offer, such as STD, workers' compensation, etc.	
3. How do you keep up to date on the numerous unique state FMLA regulations to assure that the City's FMLA administration processes will be appropriately compliant?	
4. How do you keep up to date on federal FMLA regulations and various case laws that impact FMLA?	
5. Do you have legal counsel available in order to research the City's FMLA-related questions and unique employee FMLA situations?	
6. Are you able to review the City's current FMLA policies, procedures, and practices and provide recommendations for compliance and/or process improvement?	
7. Outline your standard process for FMLA administration from call intake to case closure.	
8. What is the most common reason your firm cannot approve a FMLA request?	
9. Outline your FMLA appeals process.	
10. Indicate any specific FMLA administration services your firm is not currently able to offer.	
11. Outline how you determine an employee's eligibility for FMLA.	
12. Describe your services related to objectively verifying the validity of an FMLA request.	
13. What is the definition of a "serious health condition" that you use?	
14. Please provide the toll free phone number employees can use to contact your firm regarding their absence.	
15. When an employee calls in to report their absence situation, do they speak to a live person or a recording?	
16. When an employee calls in to report their absence situation, do they speak to the same customer service representative each time?	

FMLA ADMINISTRATION	VENDOR RESPONSE
17. Indicate if and how employees can contact your firm online if they prefer, instead of via telephone contact.	
18. What is the location for the customer service, call center that you propose to use for this client?	
19. Discuss any bilingual customer service capabilities.	
20. a. Outline any FMLA training you can provide the City's internal staff. b. Is there an additional charge for the training?	
21. What is your process if a manager/supervisor were to contact you regarding the need for documentation on a leave or for questions related to their employee's FMLA leave?	
22. Upon the start of the contract, is it your plan to take over existing leave cases or only initiate work on new FMLA leave cases?	
23. How many days will you need in order to implement your services for the City?	
24. Does your leave tracking system have the ability to track leaves down to the minute or is there some other minimum interval used?	
25. Describe the use of any licensed medical professionals in your FMLA administration services.	
26. For employees with ongoing or chronic health conditions, how often do you request objective medical information to verify the validity of the condition?	
27. What do you need from the City in order to perform your overall FMLA administration services?	
28. Outline your process for accurately tracking intermittent FMLA leave.	
29. Indicate any techniques that you have found helpful for managing intermittent FMLA, such as in the case of an employee with frequent migraines.	
30. What do you need from the City to implement better control of the City's <u>intermittent</u> FMLA leave situations?	
31. How do you measure the success of your FMLA administrative services?	
32. Outline the methods your firm plans to use for the City to reduce absence-related expenses.	
33. Indicate the types of information the City can view/obtain daily in order to oversee your FMLA administration process for their employees.	

FMLA ADMINISTRATION	VENDOR RESPONSE
34. Indicate the types of FMLA tracking reports you can provide that address utilization by employees, recertification of FMLA, intermittent FMLA, etc.	
35. List the categories of leave (e.g. qualifying reasons for leave) that you can report for the City.	
36. List the general types of serious health conditions related to an employee's own personal leave that you can report for the City.	
37. Describe any benchmarking data capabilities you can report to compare the City's FMLA stats to similar organizations/industries.	
38. Please provide a copy of the correspondence you provide to an employee who requests FMLA in your proposal response.	
39. Please provide a copy of all reports you can provide for the City related to your FMLA Administration services in your proposal response.	
40. Please provide examples of employee FMLA education that you recommend the City use.	
41. Please confirm you will accept payroll feeds from the City to update intermittent leave information. Please confirm this will be an electronic process, not manual.	
42. Please confirm your system recognizes a varied work schedule not just 5 days a week, 8 hours a day (e.g. firefighters work 48 hours on and 96 hours off).	

For the following categories, provide the performance standard you are willing to offer, the financial penalty (maximum dollar amount or % premiums or service fees) you will agree to pay if the standard is not met, and the method of measuring the penalty for each funding type proposed. **If your proposal includes performance guarantees that are different by line of coverage, please complete this table for each line.**

PERFORMANCE GUARANTEES	VENDOR RESPONSE	FINANCIAL PENALTY (Maximum Dollar Amount of % of Premiums or Service Fees)
<p>1. <u>Vendor attendance at City meetings</u></p> <p>Attendance by vendor representatives when requested at meetings scheduled by the City during the contract period and implementation phase.</p>		
<p>2. <u>Vendor call (or e-mail) return timeliness</u></p> <p>The City or designated consultant's calls (or e-mails) to vendor are returned within 24 clock hours.</p>		
<p>3. <u>Processing eligibility updates</u></p> <p>All updates to eligibility or enrollment records will be made within 3 business days after the information is received by the vendor.</p>		
<p>4. <u>Telephone call availability & answering speed</u></p> <p>90% of all calls are answered within 30 seconds, and telephone service is available between 8:00 am and 6:00 pm Arizona Time Zone on business days.</p>		
<p>5. <u>Telephone call on-hold (in-queue) time</u></p> <p>An average of less than 2 minute(s) on hold before a <u>human being</u> answers.</p>		
<p>6. <u>Telephone Abandonment Rate</u></p> <p>An abandonment rate of less than 3% is maintained during standard business hours.</p>		
<p>7. <u>Claims Processing Accuracy</u></p> <p>99% of claims dollars submitted for payment will be accurately processed and paid. Regardless of whether or not these standards of performance are satisfied, the vendor must reimburse the City for all overpayments that are not recovered from the recipient within 60 days after the overpayment is discovered. The City will assign its right to recover any such overpayments to the vendor.</p>		

PERFORMANCE GUARANTEES	VENDOR RESPONSE	FINANCIAL PENALTY (Maximum Dollar Amount of % of Premiums or Service Fees)
<p>8. <u>Turnaround Time on Claims Payments</u></p> <p>95% of all claims received will be completely processed (paid, denied, or pending for additional information) within 14 calendar days after they are received. 100% of claims will be processed within 30 calendar days of receipt.</p>		
<p>9. <u>Elevated Claim Issues</u></p> <p>When the City contacts you with an elevated claim issue via telephone or email directly or through their consultant you will respond within 24 hours and provide progress reports every 48 hours until the issue is resolved.</p>		
<p>10. <u>Timeliness of Claim Reports</u></p> <p>Each report the vendor will supply the City will be provided within a mutually agreed upon timeframe.</p>		
<p>11. <u>Claims Coding</u></p> <p>99% of all claims will be coded with no errors.</p>		
<p>12. <u>Implementation</u></p> <p>Successful implementation as defined by key milestones. Include measurable milestones in your proposal.</p>		
<p>13. <u>Data Exchange</u></p> <p>Receive and transmit the City's data with vendors based on a frequency defined by the business needs of the City.</p>		
<p>14. <u>Network Discounts</u></p> <p>Achievement of self-reported discounts (as responded to in the Network Composition section of this Questionnaire).</p>		
<p>15. <u>Network Size</u></p> <p>Agree to maintain the size of the network as provided by your Geo Access report.</p>		

**EXHIBIT 4
OFFER AND ACCEPTANCE**

To the City of Buckeye, Arizona:

The undersigned hereby offers and agrees to furnish the materials in compliance with all terms, conditions, specifications and amendments in the Solicitation. Signature also certifies understanding and compliance with the City Of Buckeye's Standard Terms and Conditions.

COMPANY NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NO: _____

FAX: _____

CONTACT PERSON: _____

AUTHORIZED COMPANY SIGNATURE: _____

THIS FORM MUST BE SIGNED AND RETURNED WITH PROPOSAL

ACCEPTANCE OF OFFER
(For City use only)

The Offer is hereby accepted.

The Contractor is now bound to provide the services as specified herein in accordance with all terms, conditions, specifications amendments, etc. and the Contractor's Offer as accepted by the

The contract is for:

The Contractor is cautioned not to provide any materials under this contract until the Contractor receives an executed purchase order.

Awarded this _____ day of _____, 2018

Purchasing Agent

**EXHIBIT 5
NON-COLLUSION AFFIDAVIT**

State of _____)
County of _____) ss.

_____ affiant,
(Name)

the _____
(Title)

(Contractor/Bidder)

The persons, corporation, or company who makes the accompanying Proposal, having first been duly worn, deposes and says:

That such Proposal is genuine and not sham or collusive, nor made in the interest of, or behalf of, any persons not herein named, and that the Offeror has not directly or indirectly induced or solicited any other Offeror to put in a sham bid, or any other person, firm or corporation to refrain from bidding, and that the Offeror has not in any manner sought by collusion to secure for itself an advantage over any other Offeror.

(Title)

Subscribed and sworn to before me

this _____ day of _____, 2018

Signature of Notary Public in and for the

State of _____

County of _____

**EXHIBIT 6
DEVIATIONS / EXCEPTIONS**

List any deviation or exception for any item listed in this solicitation. The item number must be listed and the page it is found on. Any deviation/exception or inability of the provider to handle that particular item must be clearly and fully stated. Failure to show specific deviations indicates full compliance with this solicitation.

The undersigned hereby acknowledges that there are ***no deviations/exceptions*** to this solicitation:

Firm

Authorized Signature

**EXHIBIT 7
CONFLICT OF INTEREST CERTIFICATION**

City of Buckeye
Construction and Contracting Division
530 East Monroe Avenue
Buckeye, Arizona 85326

The undersigned certifies that to the best of his/her knowledge: **(check only one)**

() There is no officer or employee of the City of Buckeye who has, or whose relative has, a substantial interest in any contract resulting from this request.

() The names of any and all public officers or employees of the City of Buckeye who have, or whose relative has, a substantial interest in any contract resulting from this request, and the nature of the substantial interest, are included below or as an attachment to this certification. In compliance with Request for Proposal No. **2018008**, for the **Group Insurance Benefits** and after carefully reviewing all the terms, conditions and requirements contained therein, the undersigned agrees to furnish such good/services in accordance with the specifications/scope of work.

Contractor Name: _____

Address: _____

City: _____, **State:** _____, **Zip Code:** _____

(signature required)

(print name) _____
(phone/fax)

(print title) _____
(Federal Taxpayer ID Number)

(date)

**EXHIBIT 8
PRIOR AND PENDING LAWSUITS**

Name of Company:

Signature:

Date: _____

Describe any pending or closed lawsuits against your organization in the past five (5) year below.

EXHIBIT 9
INTENT TO PROPOSE

Due Date: November 19, 2018

Email: rcalisi@segalco.com

Attn: Ms. Rachel Calisi

Re: City of Buckeye - Request for Proposals Solicitation No. 2018008

We are in receipt of the above referenced RFP and will/will not be quoting the following service:

Services	Yes	No	Reason for Decline
Basic Life			
Voluntary Life Insurance			
Basic & Voluntary AD&D			
Short Term Disability			
Medical Care			
Voluntary Dental			
Voluntary Vision			
Flexible Spending Account Administration			
COBRA Administration			
FMLA Administration			
Employee Assistance Program			

Name of Company

Address

Phone Number

Signature

**EXHIBIT 10 - PPO
(Current Plan)**

Vendor Directions: In completing this, indicate **ONLY** where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Types of Coverage	Current/Requested		Proposed	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible	\$500/Person	\$1,000/Person		
	\$1,000/Family	\$3,000/Family		
	Family members meet only their individual deductible and then their claims covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims paid at the plan coinsurance.			
Out-of-Pocket Maximum	\$2,000/Person \$4,000/Family	\$4,000/Person \$8,000/Family		
	Family members meet only their individual out-of-pocket and then their claims covered at 100%; if the family out-of-pocket has been met prior to their individual out-of-pocket being met, their claims will be paid at 100%.			
Lifetime Maximum	Unlimited			
Maximum Allowable Charge	Not Applicable	110% of Medicare		
Preventive Care				
Routine Preventive Care & Immunizations	No charge	70%		
Physician Services				
Primary Care Physicians Visits	\$25 copay/visit	70%		
Specialist Office Visits	\$40 copay/visit	70%		
Outpatient Services				
Surgeon//Physician	90%	70%		
Facility	90%	70%		
Emergency Medical				
Urgent Care	\$40 copay/visit (waived if admitted)			
Emergency Room	\$150 copay/visit (waived if admitted)			
Ambulance	100%			
Hospital Care				
Physician	90%	70%		
Facility	90%	70%		
Skilled Nursing Facility				
	90%	70%		

**EXHIBIT 10 - PPO
(Current Plan)**

Vendor Directions: In completing this, indicate **ONLY** where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Types of Coverage	Current/Requested		Proposed	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Maximum	60 days			
Laboratory & Radiology Services				
Diagnostic Test (x-ray, blood work)	90%	70%		
Imaging (CT/PET scans, MRIs)	90%	70%		
Behavioral Health Services				
Inpatient	90%	70%		
Outpatient Office Visit	\$40 copay/visit	70%		
Outpatient Facility	90%	70%		
Substance Abuse				
Inpatient	90%	70%		
Outpatient Office Visit	\$40 copay/visit	70%		
Outpatient Facility	90%	70%		
Maternity Care				
Physician Office Visit	\$20 PCP/\$35 Specialist for 1 st visit; 90% thereafter	70%		
Delivery	90%	70%		
Rehabilitation and Chiropractic	\$20 PCP/\$35 Specialist	70%		
	20 days/calendar year all therapies combined			
Cardiac Rehab	\$25 PCP/\$40 Specialist	70%		
	36 Days Calendar Year Maximum			
Home Health	90%	70%		
	16 hour maximum per day			
Hospice (inpatient and outpatient)	90%	70%		
Durable Medical Equipment	90%	70%		
Pharmacy				
Retail – 30 day supply	Tier 1 \$10	50% (Retail only)		
	Tier 2 \$25			

**EXHIBIT 10 - PPO
(Current Plan)**

Vendor Directions: In completing this, indicate **ONLY** where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Types of Coverage	Current/Requested		Proposed	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Mail Order – 31-90 day supply	Tier 3	\$50		
	Tier 1	\$20		
	Tier 2	\$50		
	Tier 3	\$100		

**EXHIBIT 11 - HDHP
(Current Plan)**

Vendor Directions: In completing this, indicate **ONLY** where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Types of Coverage	Current/Requested		Proposed	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible	\$2,000/Person	\$4,000/Person		
	\$4,000/Family	\$8,000/Family		
Out-of-Pocket Maximum	\$5,000/Person \$10,000/Family	\$10,000/Person \$20,000/Family		
	Family members meet only their individual out-of-pocket and then their claims covered at 100%; if the family out-of-pocket has been met prior to their individual out-of-pocket being met, their claims will be paid at 100%.			
Lifetime Maximum	Unlimited			
Maximum Allowable Charge	Not Applicable	110% of Medicare		
Preventive Care				
Routine Preventive Care & Immunizations	No charge	50%		
Physician Services				
Primary Care Physicians Visits	80%	50%		
Specialist Office Visits	80%	50%		
Outpatient Services				
Physician/Surgeon,	80%	50%		
Facility	80%	50%		
Emergency Medical				
Urgent Care	80%			
Emergency Room	80%			
Ambulance	80%			
Hospital Care				
Physician/Surgeon,	80%	50%		
Facility	80%	50%		
Skilled Nursing Facility				
	80%	50%		
Calendar Year Maximum	60 days			
Laboratory & Radiology Services				
Diagnostic Test (x-ray, blood work)	80%	50%		

**EXHIBIT 11 - HDHP
(Current Plan)**

Vendor Directions: In completing this, indicate **ONLY** where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Types of Coverage	Current/Requested		Proposed	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Imaging (CT/PET scans, MRIs)	80%	50%		
Behavioral Health Services				
Inpatient	80%	50%		
Outpatient Office Visit	80%	50%		
Outpatient Facility	80%	50%		
Substance Abuse				
Inpatient	80%	50%		
Outpatient Office Visit	80%	50%		
Outpatient Facility	80%	50%		
Maternity Care				
Physician Office Visit	80%	50%		
Delivery	80%	50%		
Rehabilitation and Chiropractic	80%	50%		
	20 days/calendar year all therapies combined			
Cardiac Rehab	80%	50%		
	36 Days Calendar Year Maximum			
Home Health	80%	50%		
	16 hours maximum per day			
Hospice (inpatient and outpatient)	80%	50%		
Durable Medical Equipment	80%	50%		
Pharmacy				
	80%	50% (Retail only)		

**EXHIBIT 12 - HMO
(Current Plan)**

Vendor Directions: In completing this, indicate **ONLY** where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Types of Coverage	Current/Requested		Proposed	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible	\$500/Person	Not Applicable		
	\$1,000/Family			
	Family members meet only their individual deductible and then their claims covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims paid at the plan coinsurance.			
Out-of-Pocket Maximum	\$5,000/Person \$10,000/Family	Not Applicable		
	Family members meet only their individual out-of-pocket and then their claims covered at 100%; if the family out-of-pocket has been met prior to their individual out-of-pocket being met, their claims will be paid at 100%.			
Lifetime Maximum	Unlimited			
Maximum Allowable Charge	Not Applicable	Not Applicable		
Preventive Care				
Routine Preventive Care & Immunizations	No charge	No coverage		
Physician Services				
Primary Care Physicians Visits	\$35 copay/visit	No Coverage		
Specialist Office Visits	\$50 copay/visit	No Coverage		
Emergency Medical				
Ambulance	100%			
Urgent Care	\$50 copay/visit (waived if admitted)			
Emergency Room	\$150 copay/visit (waived if admitted)			
Hospital Care				
Physician	100%	No Coverage		
Facility	90%	No Coverage		
Skilled Nursing Facility				
	90%	No Coverage		
Calendar Year Maximum	60 days			
Laboratory & Radiology Services				

**EXHIBIT 12 - HMO
(Current Plan)**

Vendor Directions: In completing this, indicate **ONLY** where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Types of Coverage	Current/Requested		Proposed	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic Test (x-ray, blood work)	100%	No Coverage		
Imaging (CT/PET scans, MRIs)	100%	No Coverage		
Behavioral Health Services				
Inpatient	90%	No Coverage		
Outpatient Office Visit	\$35 copay/visit	No Coverage		
Outpatient Facility	100%	No Coverage		
Substance Abuse				
Inpatient	90%	No Coverage		
Outpatient Office Visit	\$35 copay/visit	No Coverage		
Outpatient Facility	100%	No Coverage		
Maternity Care				
Physician Office Visit	100%	No Coverage		
Delivery	90%	No Coverage		
Rehabilitation and Chiropractic	\$35 PCP/\$50 Specialist	No Coverage		
	20 days/calendar year all therapies combined			
Cardiac Rehab	\$35 PCP/\$50 Specialist	No Coverage		
	36 Days Calendar Year Maximum			
Home Health	100%	No Coverage		
	16 hours maximum per day			
Hospice	90% (inpatient)	No Coverage		
	100% (outpatient)	No Coverage		
Durable Medical Equipment	100%	No Coverage		
Pharmacy				
	Retail = Tier 1 = \$15 Tier 2 = \$30 Tier 3 = \$60 Mail = 2x Retail Copay)	In-Network Coverage Only		

**EXHIBIT 13 – DPPO High Dental Plan
(Current Plan)**

Vendor Directions: In completing this, indicate **ONLY** where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Types of Coverage	Current/Requested		Proposed	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible (Individual/Family)	\$50/\$150	\$50/\$150		
Calendar Year Maximum	\$5,000	\$5,000		
Reimbursement Level	Contracted Fee	90 th Percentile of R & C		
PREVENTIVE & DIAGNOSTIC SERVICES				
Exams, evaluations or consultations (Twice/Contract Year)	100%	100%		
Cleanings (Twice/Contract Year)	100%	100%		
Fluoride Treatments (Once/Contract Year for Children Under 19)	100%	100%		
Bitewing X-rays (Twice/ Contract Year)	100%	100%		
Full Mount/Panoramic/Periapical X-rays	100%	100%		
Space Maintainers (non-Orthodontic treatment)	100%	100%		
Sealants (Posterior tooth, Once per tooth/36 months)	100%	100%		
*Once every 36 months				
BASIC RESTORATIVE SERVICES				
Emergency Care to Relieve Pain	80%	80%		
Fillings (amalgam and composite/resin)	80%	80%		
Root Canal Therapy/Endodontics	80%	80%		
Osseous Surgery	80%	80%		
Periodontal Scaling & Root Planing	80%	80%		
Denture Adjustments and Repairs	80%	80%		
Oral Surgery – Simply Extractions	80%	80%		
Oral Surgery – All Except Simple Extractions	80%	80%		
Anesthetics	80%	80%		
Surgical Extractions of Impacted Teeth	80%	80%		
Repairs to Bridges, Crowns, & Inlays	80%	80%		

**EXHIBIT 13 – DPPO High Dental Plan
(Current Plan)**

Vendor Directions: In completing this, indicate **ONLY** where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Types of Coverage	Current/Requested		Proposed	
	In-Network	Out-of-Network	In-Network	Out-of-Network
MAJOR RESTORATIVE SERVICES				
Crowns	50%	50%		
Dentures	50%	50%		
Bridges	50%	50%		
Inlays/Onlays	50%	50%		
Prosthesis Over Implant* *Once every 60 months, if unserviceable.	50%	50%		
Implants	50%	50%		
ORTHODONTIC SERVICES (Dependent Children to Age 19)	50%	50%		
Lifetime Maximum	\$1,000	\$1,000		

**EXHIBIT 14 – DPPO Low Dental Plan
(Current Plan)**

Vendor Directions: In completing this, indicate **ONLY** where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Types of Coverage	Current/Requested		Proposed	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible (Individual/Family)	\$50/\$150	\$50/\$150		
Calendar Year Maximum	\$1,500	\$1,000		
Reimbursement Level	Contracted Fee	Contracted Fee (In-Network Level)		
PREVENTIVE & DIAGNOSTIC SERVICES				
Exams, evaluations or consultations (Twice/Contract Year)	100%	60%		
Cleanings (Twice/Contract Year)	100%	60%		
Fluoride Treatments (Once/Contract Year for Children Under 19)	100%	60%		
Bitewing X-rays (Twice/ Contract Year)	100%	60%		
Full Mount/Panoramic/Periapical X-rays*	100%	60%		
Space Maintainers (non-Orthodontic treatment)	100%	60%		
Sealants (Posterior tooth, Once per tooth/36 months)	100%	60%		
*Once every 36 months				
BASIC RESTORATIVE SERVICES				
Emergency Care to Relieve Pain	80%	30%		
Fillings (amalgam and composite/resin)	80%	30%		
Root Canal Therapy/Endodontics	80%	30%		
Osseous Surgery	80%	30%		
Periodontal Scaling & Root Planing	80%	30%		
Denture Adjustments and Repairs	80%	30%		
Oral Surgery – Simply Extractions	80%	30%		
Oral Surgery – All Except Simple Extractions	80%	30%		
Anesthetics	80%	30%		
Surgical Extractions of Impacted Teeth	80%	30%		
Repairs to Bridges, Crowns, & Inlays	80%	30%		
MAJOR RESTORATIVE SERVICES				
Crowns	50%	20%		
Dentures	50%	20%		
Bridges	50%	20%		
Inlays/Onlays	50%	20%		

**EXHIBIT 14 – DPPO Low Dental Plan
(Current Plan)**

Vendor Directions: In completing this, indicate **ONLY** where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Types of Coverage	Current/Requested		Proposed	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prosthesis Over Implant* *Once every 60 months, if unserviceable.	50%	20%		
Implants	50%	20%		
ORTHODONTIC SERVICES (Dependent Children to Age 19)	50%	50%		
Lifetime Maximum	\$1,000	\$1,000		

EXHIBIT 15 – Dental Plan Limitations

Vendor Directions: Complete this chart in it's entirety.

Benefit Limitations	Proposed Plan – DPPO High Plan	Proposed Plan – DPPO Low Plan
Exams		
Late Entrant		
Missing Tooth		
Fluoride		
X-Rays (routine)		
X-Rays (non-routine)		
Models		
Fillings		
Sealants		
Crowns/Inlays/Bridges/Dentures & Partial		
Relines/Rebases		
Prosthesis over Implant		
Implant		
Posterior Teeth (Silver or White Billings) – please indicate what is provided		
Anterior Teeth (Silver or White Billings) – please indicate what is provided		

EXHIBIT 16 - VISION PLAN SCHEDULE OF BENEFITS - Option 1

Indicate ONLY where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Type of Coverage	Current		Proposed	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Benefit Frequency				
Exam	Once every 12 months			
Lenses	Once every 12 months			
Frames	Once every 12 months			
Exam:	\$20 copay	\$35		
Lenses:				
Single	\$20 copay	\$25		
Bifocal	\$20 copay	\$40		
Trifocal	\$20 copay	\$55		
Lenticular	20% discount	No benefit		
Frames:	Any frame available at provider location			
	Up to \$130 Retail	Up to \$65 Retail		
Contacts				
Elective	Up to \$130	Up to \$104		
Medically Necessary	\$0 copay; paid in full	Up to \$200		

EXHIBIT 17 - VISION PLAN SCHEDULE OF BENEFITS – Option 2

Indicate ONLY where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Type of Coverage	Current		Proposed	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Benefit Frequency				
Exam	Once every 12 months			
Lenses	Once every 12 months			
Frames	Once every 12 months			
Exam:	\$15 copay	\$45		
Lenses:				
Single	\$15 copay	\$30		
Bifocal	\$15 copay	\$50		
Trifocal	\$15 copay	\$65		
Lenticular	\$15 copay	\$100		
Frames:	Any frame available at provider location			
	Up to \$120 Retail	Up to \$70 Retail		
Contacts				
Elective	Up to \$120	Up to \$105		
Medically Necessary	\$0 copay; paid in full	Up to \$210		

EXHIBIT 18- BASIC LIFE AND AD&D

Indicate ONLY where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Type of Coverage	Current Plan	Proposed Plan
Basic Benefit	1 X BAE rounded to next higher \$1,000; \$30,000 minimum, \$200,000 maximum	
Guarantee Issue	\$200,000	
Benefit Reduction (All Eligible Employees Other than Elected Officials)	65% at age 70 45% at age 75 30% at age 80	
Benefit Reduction (All Eligible Elected Officials)	67% at age 70 50% at age 75	
Continuation Options		
Layoff	Up to 1 month	
Leave of Absence	Up to 1 month	
FMLA	12 weeks	
Disability over age 60	12 months	
Portability	Yes, up to age 70.	
Waiver of Premium	Included, to age 70, after 9 months of disability.	
Terminal Illness Benefit	75% of Life Insurance Benefit, up to a maximum of \$500,000.	

EXHIBIT 19 – VOLUNTARY LIFE AND AD&D

Indicate ONLY where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Type of Coverage	Current Plan	Proposed Plan
Employee Amount	Amount elected in \$10,000 increments, up to a maximum of \$300,000 or 5 times earnings, whichever is less	
Spouse/Domestic Partner Amount	Amount elected in \$10,000 increments, up to a maximum of \$150,000 or 50% of employee amount, whichever is less	
Child(ren) Amount	\$10,000 unit (\$500 less than 6 months)	
Guarantee Issue		
Employee	\$100,000	
Spouse/Domestic Partner	\$10,000	
Child(ren)	\$10,000	
Benefit Reduction	65% at age 70 45% at age 75 30% at age 80	
Continuation Options		
Layoff	Up to 1 month	
Leave of Absence	Up to 1 month	
FMLA	12 weeks	
Disability over age 60	12 months	
Waiver of Premium	Included, to age 70, after 9 months of disability. Premium waived for employee, spouse, and child(ren) life amounts	
Portability	Yes, up to age 70 for employee, spouse, domestic partner, and child(ren)	
Terminal Illness Benefit	75% of Life Insurance Benefit, up to a maximum of \$500,000.	

EXHIBIT 20 – ACCIDENTAL DEATH & DISMEMBERMENT (BASIC and VOLUNTARY)

Indicate ONLY where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Type of Coverage	Current Plan	Proposed Plan
For Loss Of:		
Life	Principal Sum	
Speech AND Hearing (in both ears)	Principal Sum	
Quadriplegia	Principal Sum	
Paraplegia	75% of Principal Sum	
Sight of One Eye	50% of Principal Sum	
Hemiplegia	50% of Principal Sum	
Thumb AND Index Finger of Same Hand	25% of Principal Sum	
Other:		
Seat Belt Benefit:		
Benefit Amount	25% of Principal Sum	
Maximum Benefit Payment	\$25,000	
Air Bag Benefit:		
Benefit Amount	10% of Principal Sum	
Maximum Benefit Payment	\$10,000	
Education Benefit (Applies to Voluntary Coverage Only)		
Benefit Availability	Surviving Dependent Child	
Benefit Amount	3% of Principal Sum	
Maximum Annual Benefit Amount	\$3,000	
Maximum Number of Annual Payments	4	
Rehabilitative Training Benefit (Applies to Voluntary Coverage Only)		
Benefit Amount	25% of Principal Sum	
Maximum Benefit Amount	\$5,000	
Child Care Benefit (Applies to Voluntary Coverage Only)		
Benefit Amount	3% of Principal Sum	
Maximum Annual Benefit Amount	\$1,000	
Maximum Number of Annual Payments	4	

EXHIBIT 21 – SHORT TERM DISABILITY

Indicate ONLY where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Type of Coverage	Current Plan	Proposed Plan
Elimination Period	7 days for accident or sickness	
Weekly Benefit	66 2/3% of salary covered salary	
Maximum Weekly Benefit	\$1,500	
Minimum Weekly Benefit	\$25.00	
Maximum Benefit Period	25 weeks	
Definition of Disability	Own occupation	
Partial Disability	20% or more loss of earnings	
Return to Work Incentive	Included up to 100% of covered earnings when combining the disability benefit and disability earnings	
Offsets	Amounts eligible Unemployment compensation law, compulsory Benefit Act or Law, or other act or law of like intent; any labor management trustee, union or employee benefit plans that are funded in whole or in part by your Employer; any disability income benefit you are eligible for under any other group insurance plan of your employer, any governmental retirement system as a result of your job with your Employer; accumulated sick leave; any salary continuation paid to you by your employer which causes your weekly STD benefit, plus other income benefits and any salary continuation to be more than 100% of your total weekly earnings.	
Recurring Disability	Included if return to work is within 14 days after receiving	

EXHIBIT 21 – SHORT TERM DISABILITY

Indicate ONLY where the benefits of your proposed plan differ from the current. If the same as current, leave blank and it will be assumed you are duplicating the current benefit.

Type of Coverage	Current Plan	Proposed Plan
	disability benefits	
Rehabilitation Program	Voluntary rehabilitation program	
Continuation of Coverage	Up to 12 weeks for personal or family medical leave; end of the month in which any other approved leave of absence began	
Exclusions	Intentionally self-inflicted injuries; active participation in a riot, rebellion or insurrection; a war, or any act of war; committing or attempting to commit an assault, felony, or other criminal act; injury or sickness for which you are entitled to benefits under any Workers' Compensation, Occupational Disease or similar law; injury or sickness sustained while you are doing any act of thing pertaining to any occupation for wage or profit.	

ATTACHMENTS

Attachment A:	Life, AD&D, and STD Policy
Attachment B:	Financial Workbook ⁽¹⁾
Attachment C:	Census ⁽¹⁾
Attachment D:	Medical Summary Benefits Coverage
Attachment E:	DPPO High Benefit Summary
Attachment F:	DPPO Low Benefit Summary
Attachment G:	Vision Benefit Summary (Option 1)
Attachment H:	Vision Benefit Summary (Option 2)
Attachment I:	Medical, Dental, and Vision Experience (7/1/2016 to 6/30/2017)
Attachment J:	Medical, Dental, and Vision Experience (7/1/2017 to 6/30/2018)
Attachment K:	Medical, Dental, and Vision Experience (7/1/2018 to 8/31/2018)
Attachment L:	AZ House Bill 2502 Outline
Attachment M:	Medical Large Claims (7/1/2016 to 6/30/2017) ⁽¹⁾
Attachment N:	Medical Large Claims (7/1/2017 to 6/30/2018) ⁽¹⁾
Attachment O:	Medical Large Claims (7/1/2018 to 8/31/2018) ⁽¹⁾
Attachment P:	Life, AD&D, & STD Claims Report
Attachment Q:	Life, AD&D, & STD Premium, Volume, and Lives Report
Attachment R:	EAP Utilization Report

⁽¹⁾ Due to HIPAA regulations, the census and Financial Workbook files have not been included in the RFP. Vendors should complete and sign the Confidentiality Agreement contained as Exhibit A. The completed form should be emailed to rcalisi@segalco.com. Upon receipt, the census and Financial Workbook will be sent via secure email from Segal Consulting, the City's Employee Benefit Consultant.