



Request for Proposals

RFP – 2016-12-34

Employee Dental and Voluntary Vision Insurance

Sealed proposals will be received until
12:00 p.m. on Thursday June 16, 2016

Return RFP To: *City of Copperas Cove*

Attn: Velia Key

914 South Main Street, Suite H

P.O. Drawer 1449

Copperas Cove, TX 76522



TO: Interested Insurance Carriers

RE: Request for Proposal City of Copperas Cove Employee Benefit Trust

May 13, 2016

Insurance Carriers:

I am writing to your company on behalf of the City of Copperas Cove Employee Benefit Trust, hereafter referred to as the "Planholder", requesting that you prepare a proposal reflecting your charges for Dental and Vision Coverage. Our current Dental and Vision Insurance is underwritten by Assurant Employee Benefits.

The City of Copperas Cove is one of the largest local employers with about 275 full time employees providing police and fire protection, library services, water and sewer services, and parks and recreation as well as many others.

Deadline for any questions or requests for clarification must be submitted to **Velia Key, Director of Finance, City of Copperas Cove, in writing via email at vkey@copperascovetx.gov** prior to 12:00 pm May 27, 2016. There will be no exceptions. All responses to the questions will be sent to all Proposers.

Submission of Proposals: Please provide **Two (2) copies of all proposal documents, along with one (1) electronic version of the submission in a PDF and Excel format on DVD/CD.** Proposals must include all exhibits and answers to specific questions and shall be sealed and submitted **no later than 12:00 pm on Thursday June 16, 2016:**

Mailing Address:

**City of Copperas Cove
Attn: Finance Department
P.O. Drawer 1449
Copperas Cove, TX 76522**

Delivery Address:

**City of Copperas Cove
Attn: Finance Department
914 South Main Street, Suite H
Copperas Cove, TX 76522**

MARK ENVELOPE: "RFP NO. 2016-12-34; EMPLOYEE DENTAL AND VISION INSURANCE"

Late proposals will not be accepted.

Selection: Recognizing the fact that there are very important considerations involved in selecting an insurance carrier, the Planholder is not bound to accept the lowest proposal. The Planholder reserves the right to reject any or all proposals or to accept any proposal deemed advantageous to the Planholder. The award of the contract shall be made to the responsible offerer, whose proposal is determined to be the most advantageous offer resulting from negotiation, taking into consideration the relative importance of price and other evaluation factors set forth in the Request for Proposals in accordance with Texas Local Government Code, Chapter 252. Proposals will be evaluated based on the following criteria and in the following order (with #1 being the most important):

1. OFFERER'S GROSS PREMIUM (40%)
2. OFFERER'S AVAILABILITY OF LOCAL DENTAL AND VISION PROVIDERS (25%)
3. OFFERER'S SUPPORT/SERVICES PROVIDED INCLUDING ABILITY TO PARTNER WITH AND SUBSIDISE THE COST OF THE CITY'S ROBUST ONLINE ENROLLMENT SYSTEM PLANSOURCE AS WELL AS PROCESS 834 FILE FEEDS. (20%)
4. OFFERER'S QUALIFICATIONS/EXPERIENCE (15%)

QUALIFICATIONS

1. All companies submitting proposals must be licensed by the State of Texas and be permitted to contract with the State or any of its subdivisions. Further, it is preferred that companies be recommended in the latest edition of Best's Life Insurance Reports with a general policyholder's rating of A.
2. All companies must be authorized and able to do business with an Employee Benefit Trust, and comply with providing rates excluding premium taxes.

PLAN ADMINISTRATION QUALIFICATIONS

Planholder Responsibility

- The Planholder will provide for payroll deductions of premium and Planholder's Enrollment system PlanSource will notify the carrier of additions/deletions from the coverage through weekly file feed. The Planholder will assist in the logistics of the enrollment process.

Selected Carrier Responsibility

- The carrier **will** provide claim instructions, employee booklets outlining the benefits and instructions on filing a claim, and orientation materials. The carrier **will** participate in Open Enrollment meetings scheduled at the convenience of the City, which may include early morning and/ or evening meetings. The carrier **will** provide online access to identification cards, EOB's and appropriate communication materials deemed necessary by the Planholder to properly administer the Plan Benefits.
- The carrier will provide the following claim reports upon request:
 1. Summary of Paid Claims
 2. Network Disruption Report

GENERAL INFORMATION AND INSTRUCTIONS

1. All proposals must be received at the designated location by the deadline shown. Proposals received after the deadline shall be considered void and unacceptable. The City of Copperas Cove Employee Benefits Trust is not responsible for non-delivery of mail, carrier, etc.
2. Proposals are anticipated to provide a 12-month rate guarantee, with a contract period of October 1, 2016 through September 30, 2017. Preference will be given to companies that are able to provide multiple year rate guarantees or multiple year rate guarantees based on claims performance. Premium rates proposed must be firm and not subject to change based upon enrollment.
3. The Planholder reserves the right to reject any and all proposals and to accept any proposal deemed advantageous to the Planholder. Receipt of any proposal shall under no circumstances obligate the City to accept the lowest dollar proposal. The award of this contract shall be made to the responsible Proposer whose proposal is determined to be the highest evaluated offer resulting from negotiation, taking into consideration the relative importance of price and the other evaluation factors set forth in the Request for Proposals.
4. Any direct contact by proposers or their representatives to any City officials, City Manager, or staff involved in the RFP process, other than those listed within this RFP as authorized is strictly prohibited and could result in disqualification of the proposal.
5. The Carrier must submit evidence of ability to service the group without undue requirements of the Planholder. Each Carrier should list as references groups that it services that are approximately the same number of participants as the City of Copperas Cove Employee Benefits Trust. References may be checked if deemed advisable. (Form provided)
6. Your proposal must conform in all respects to the specifications outlined in this letter and attached exhibits. If your company's practice prohibits you from submitting a proposal on the same basis as outlined in the specifications, you may submit a proposal on a basis that is in accordance with your practice. Please state clearly, in detail, any deviation from the specifications outlined in this letter

with complete reference to the provision from which the deviation is being made.

7. Dental Proposals must be quoted with an even number and based on benefits similar to the current plan; with special consideration to Preventive Care services that do not count toward annual benefit maximums.
8. Vision Proposals should also be quoted with an even number and include coverage for both Glasses and Contacts and provide discounts or pricing outline for add on products not limited to the following; No-line, transition lenses, scratch coat, UV protection and Anti reflective lenses.
9. The current plan is through an agent; a proposal submitted to provide health care benefits should be inclusive of standard commissions.
10. HIPAA Compliance with Privacy & Confidentiality guidelines will be required. Specifically, Plan Sponsor certifies that:
 - PHI will not be used or disclosed other than as permitted by plan documents or required by law;
 - Any agents and subcontractors of Plan Sponsor have agreed as part of their contracts with Plan Sponsor to the same restrictions and conditions with regard to use of PHI; and
 - PHI shall not be used for employment or benefit-related decisions.
11. Proposals must include coverage on all eligible full-time employees and with optional coverage available for dependent coverage. Fulltime is defined as 30 hours or more per week. Dependent is defined as the employees' legal spouse and/or domestic partner as well as child(ren) from birth to age 26. Adopted child(ren), stepchild(ren) or foster child(ren) who is in a legal parent-child relationship is also classified as eligible dependents. Children who are currently disabled will be covered as long as they are totally disabled and dependent upon support from their parents.
12. Waiting Period: Newly hired employees and their dependents must complete up to a 60 day waiting period before becoming eligible for coverage.
13. Eligibility: All full-time employees and their dependents are eligible for benefits on the 1st of the month following 60 days of employment. Retired employees and their dependents may continue participation after retirement through their continued payment of premiums or under COBRA. Terminated employees may continue coverage under COBRA.
14. If proposed contracts are to replace existing contracts of the same type, the new contract must assume the current policy benefit structure and provide a "no loss / no gain" assumption of risk, and give credit for all annual deductibles.
15. The employee has the option of electing to pre-tax 125 premiums for out of pocket expenditures for Dental and Vision insurance premiums.
16. Currently the employer offers one Dental plan with the current carrier with the employer paying 100% of the Employee Only Premium. The employer pays 0% of the dependent premium and 0% of the retiree premium on plans offered. Vision Plans are 100% Voluntary. This is subject to approval by the governing body.
17. Please complete the appropriate enclosed proposal forms, these attachments include:
 - Vendor Information (Attachment A)
 - Proposal form including rate information (Attachment B)
 - Summary/Comparison of benefits (MUST be completed in Excel) (Attachment C)
 - References (Attachment D)
 - Questionnaire (Attachment E)

All who submit proposals, including the current carrier or administrator, shall complete the proposal forms provided. An authorized official of the carrier must sign all proposal forms submitted.

Please remember to include a declaration of compliance for HIPPA within your RFP submission.

FAILURE TO COMPLETE ALL PROPOSAL FORMS MAY RESULT IN PROPOSAL BEING DISQUALIFIED

Enclosed are the following Attachments which, together with the letter, will serve as the basis for your proposal.

ATTACHMENTS:

- Attachment A - is the form to provide your information.
- Attachment B Dental - is the form for your Dental Insurance costs quotation based on a fully insured Two Tier Employee Only and Employee Family rate plan.
- Attachment B Vision – is the form for your Vision Insurance cost quotation based on a fully insured Four Tier rate.
- Attachment C Dental - is the form to provide a comparison of the Dental plan benefits submitted in the proposal to provide a comparison to current plans. Complete the form in Excel for each plan proposed.
- Attachment C Vision – is the form to provide a comparison of the Vision plan benefits submitted in the proposal to provide a comparison to current plans. Complete the form in Excel for each plan proposed.
- Attachment D - is the form to provide information on references.
- Attachment E - Questionnaire contains specific information for your company to provide. If you do not use the form for your responses you need not repeat the questions, however, your answers must be numbered in accordance with the questionnaire.

EXHIBITS: The Exhibits listed will only be provided on written request to Velia Key, Director of Finance, City of Copperas Cove, via email at vkey@copperascovetx.gov.

- Exhibit A - Current Dental and Vision plan benefits summary.
- Exhibit B - Current Dental and Vision Insurance premium rates, claims (Dental Only) and participation history.
- Exhibit C - Census data for all full time employees.
- Exhibit D - Census data for retirees and COBRA participants.
- Exhibit E - Claims Data (Dental Only) for current plans
- Exhibit F - Top Dental Disruption report

In preparing your premium quotations, please use the forms provided and include the signature of your authorized representative.

The City of Copperas Cove is aware of the time and effort you expend in preparing and submitting proposals to the City of Copperas Cove. Please let us know of any requirements in the RFP, which are causing you difficulty in responding. We want to make this process as easy as possible so that all responsible vendors can compete for the City of Copperas Cove's business.

If you have any questions, please direct all inquiries in writing to **Velia Key, Director of Finance, City of Copperas Cove, via email at vkey@copperascovetx.gov prior to 12:00 p.m. on Friday May 27, 2016. There will be no exceptions. All responses to the questions will be sent to all Proposers.**

We look forward to receiving your proposal. This letter provides you with the information necessary for you to submit a proposal, which includes complete and carefully prepared information for consideration by the Planholder. Remember that when submitting proposals, **two (2) copies along with one (1) electronic version of the submission in a PDF and Excel format on DVD/CD** of all documents, attachments, and answers to specific questions shall be sealed and **submitted no later than Thursday June 16, 2016, at 12:00pm.**

Vendor Information

Name of Organization _____

Date Founded _____

Name of Contact Person _____

Title _____

Phone Number _____

Address _____

Email _____

Fax Number _____

Website _____

DENTAL PROPOSAL FORM

The undersigned, does hereby declare that they have read the specifications for Group Dental for the Planholder, and with full knowledge of the requirements, does hereby agree to furnish the administrative services in full accordance with the specifications and requirements. The undersigned also agrees to duplicate present coverage and if not, will attach itemized detail of any differences.

Please provide monthly Dental care costs in the table below.

	High Plan		Low Plan
Employee only			
Employee & Family			
Retiree <65			
Retiree & Family			

Dental Plan Carrier: _____

Address _____

Printed Name _____ Title _____

Signature: _____ Date _____

VOLUNTARY VISION PROPOSAL FORM

The undersigned, does hereby declare that they have read the specifications for Group Voluntary Vision for the Planholder, and with full knowledge of the requirements, does hereby agree to furnish the administrative services in full accordance with the specifications and requirements. The undersigned also agrees to duplicate present coverage and if not, will attach itemized detail of any differences.

Please provide monthly Voluntary Vision Plan costs in the table below.

	Voluntary Vision Rates
Employee only	
Employee & Spouse	
Employee & Children	
Employee & Family	
Retiree <65	
Retiree & Spouse	
Retiree & Children	
Retiree & Family	

Vision Plan Carrier: _____

Address _____

Printed Name _____ Title _____

Signature: _____ Date _____

(Electronic format is provided/ **MUST be completed in Excel**)

Carrier	
Dental Plan	In-Network Benefits
Plan Name	
Individual/Family Calendar Year Deductible	
Individual / Family Calendar Year Maximum	
Diagnostic & Preventive Services (Deductible Waived)	
Do Preventive Care Charges apply to annual maximum?	
Basic Services Percentage	
Endo / Perio Percentage	
Major Services Percentage	
Implants Covered Y/N Percentage	
Orthodontia Percentage / Lifetime Maximum / Max Age	
Waiting Period	
Out of Network Reimbursement Percentile	
Rate Guarantee	
Dental Rates	Proposed Rates (Even Numbers Please)
Employee	
Employee + Family	
Retiree <65	
Retiree + Family	

** Complete this document for each plan proposed**

(Electronic format is provided/ **MUST be completed in Excel**)

Carrier	
Voluntary Vision Plan	In-Network benefits
Copay Exam / Lenses or Frames	
Annual Eye Exam	
Single Vision / Bifocal Lenses	
Trifocal / Lenticular Lenses	
Progressive	
Frames / Allowance	
Disclose Retail / Wholesale	
Frequencies Exam/Lens/Frames	
Contact Lenses Fit & Follow up	
Contact Coverage Elective or Medically Necessary	
Network	
Out of Network Benefits Y/N	
Rate Guarantee	
Vision Rates	Proposed Rates (Even Numbers Please)
Employee	
Employee + Child/ren	
Employee + Spouse	
Employee + Family	
Retiree <65	
Retiree +Child/ren	
Retiree + Spouse	
Retiree + Family	

****Complete this document for each plan proposed****

Please provide **four** references that have been insured with your company for at least three years.

<p>COMPANY: _____ Number of employees _____</p> <p>Contact Person: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>_____</p> <p>City: _____ State _____</p> <p>Zip Code: _____</p> <p>Phone Number: _____ Fax # _____</p> <p>Email: _____</p>
<p>COMPANY: _____ Number of employees _____</p> <p>Contact Person: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>_____</p> <p>City: _____ State _____</p> <p>Zip Code: _____</p> <p>Phone Number: _____ Fax # _____</p> <p>Email: _____</p>
<p>COMPANY : _____ Number of employees _____</p> <p>Contact Person: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>_____</p> <p>City: _____ State _____</p> <p>Zip Code: _____</p> <p>Phone Number: _____ Fax # _____</p> <p>Email: _____</p>
<p>COMPANY: _____ Number of employees _____</p> <p>Contact Person: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>_____</p> <p>City: _____ State _____</p> <p>Zip Code: _____</p> <p>Phone Number: _____ Fax # _____</p> <p>Email: _____</p>

QUESTIONNAIRE

1. Please describe your company, including the structure of your company (date established, number of employees, number of insured, corporation, partnership, sole-proprietorship, etc.).
 - a. Is your company independently owned or affiliated as either a subsidiary or division of some other organization?
 - b. If affiliated with another organization, what is the major business of the parent firm?
 - c. Is any attempt or actual takeover of your company in progress? Are you planning or executing any acquisition that involves group business in excess of 20% of your current portfolio?
2. Is your company licensed to do business in the State of Texas?
3. What office would handle the general servicing of this account? What are the standard office hours for this service office? Please explain your account management team.
4. Do employees have on-line account access? If yes, please explain the online capabilities?
5. The City utilizes PlanSource as their Online Benefits Enrollment system. This robust system provides online enrollment for all Employee Benefits, houses carrier billing and ACA reporting. PlanSource is the system of record for eligibility and coverage elections. Please provide confirmation that your company will allow self-billing and that your company has the ability to receive and process EDI (Electronic Data Interface) 834 file feeds on a weekly basis. What is your standard timeframe for set up and testing? How are discrepancies handled? Will your company be willing to provide a cost offset for ongoing administration of the PlanSource system? Please outline your response.
6. Do you provide any value added services?
7. What assistance do you provide plan members if a network Dentist / Vision provider terminates their contract during the plan year? How and when are members notified? What happens to patients that are receiving on-going treatment from that network provider?
8. Describe your procedures for handling appeals of denied or disputed claims.
9. Are the rates quoted guaranteed for 12 months? Are you willing to provide a multiple year rate guarantee? If so, please outline any requirements.
10. Your contract must provide that any changes to the premium rates be effective on the policy anniversary with the additional provision that advance notice be given to the City by the last work day of April preceding the effective date of the change. Is your company willing and able to comply with these provisions?
11. Will your company honor deductibles, which have been satisfied for the current calendar year? If so, what evidence would need to be furnished?
12. Please provide a GEO Access report of In-Network Participating Dentists within a 100 mile radius of zip code 76522. Please provide the URL link for your companies Provider directory for the City of Coppertown employee service area.
13. How are providers and members of the network identified? Can the plan sponsor or plan participants nominate providers to be considered for inclusion in the network? If so, what steps would be required to be made by the plan sponsor and/or participant?

**City of Copperas Cove
October 1, 2016**

Carrier	
Voluntary Vision Plan	In-Network benefits
Copay / Lenses or Frames Exam	
Annual Eye Exam	
Single Vision / Bifocal Lenses	
Trifocal / Lenticular Lenses	
Progressive	
Frames / Allowance Disclose Retail / Wholesale	
Frequencies Exam/Lens/Frames	
Contact Lenses & Follow up Fit	
Contact Coverage Elective or Medically Necessary	
Network	
Rate Guarantee	
Out of Network Benefits Y/N	
Vision Rates	Proposed Rates (Even Numbers Please)
Employee	
Employee + Child/ren	
Employee + Spouse	
Employee + Family	
Retiree <65	
Retiree +Child/ren	
Retiree + Spouse	
Retiree + Family	

** Complete this document for each plan proposed**