



CITY OF COCONUT CREEK

FINANCE AND ADMINISTRATIVE SERVICES

PURCHASING DIVISION

4800 WEST COPANS ROAD
COCONUT CREEK, FLORIDA 33063

ADDENDUM NO. 1

March 21, 2018

RFP No.: 03-28-18-10
RFP Name: Medical with Prescription Drug, Dental, Vision, Life and AD&D, Short Term Disability, Long Term Disability, and Employee Assistance Program Insurance Services
Due Date/Time: March 28, 2018 at 10:00 a.m. EST

Our records indicate that your firm is in receipt of proposal documents for RFP No. 03-28-18-10, Medical with Prescription Drug, Dental, Vision, Life and AD&D, Short Term Disability, Long Term Disability, and Employee Assistance Program Insurance Services. This Addendum is hereby made part of the specifications and shall be included with all contract documents.

- The following information is being transmitted to address vendor questions regarding the specifications.
- ADD OR PEPLACE PAGE(S) OR ADD EXHIBITS:
 1. The Table of Contents has been revised to reflect the new Attachments.
 2. Page 46 has been replaced with Page 46(a)
 3. Page 71 has been replaced with page 71(a)
 4. Page 72 has been added
 5. Attachment 4 – Medical Disruption Report has been revised
 6. Attachment 11 – Employee Census has been revised
 7. Attachment 15 – Short Term Disability Claims Experience has been added
 8. Attachment 16 – Formulary Disruption Report has been added
 9. Attachment 17 – Large Claims PYTD has been added
 10. Attachment 18 – Vol Life Claims Experience has been added
 11. Attachment 19 – Basic Life Claims Experience has been added
 12. Attachment 20 – Long Term Disability Claims Experience has been added
 13. Attachment 21 – Long Term Disability Claims Detail no PHI has been added

Note: Words underlined and **bold** are additions, words ~~marked through~~ are deletions

This addendum acknowledgment sheet must be submitted electronically with your response through the eBid System by the due date and time indicated above. Failure to return this sheet may disqualify Proposer.

Proposer's Signature

Date

Company Name

Company Address

() _____
Phone Number

() _____
Fax Number

STACY LYSENGEN
Purchasing Analyst
slysengen@coconutcreek.net

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LONG TERM DISABILITY INSURANCE PROPOSAL FORM

| LTD | CURRENT | PROPOSED |
|--|--|----------|
| Eligible Employees | Group 1: All Full Time Police Officers in active employment working at least 84 hours per 2 week period Group 2: All Other Full Time Employees working at least 30 hours per week | |
| Definition of Disability | Limited duties and 20% or more loss in indexed monthly earnings | |
| Elimination Period | 180 days | |
| Monthly Benefit | 66.6667% of monthly earnings | |
| Maximum Benefit | \$5,000 per month | |
| Minimum Benefit | <u>Minimum monthly payment is the greater of \$100 or 10% of gross disability benefit</u> | |
| Own Occupation Period | Managers and Above – N/A; All Others - 24 months | |
| Duration of Benefit | SS ADEA or the Maximum Period of Payment (as listed in LTD COC) | |
| Pre-existing Condition Limitation | 3/12 | |
| Mental Illness & Substance Abuse Limitation | 24 Months | |
| Survivor Benefit | 3 times monthly benefit | |
| Disabled and Working Benefit (See attached Policy) | Disability earnings between 20% and 80% of indexed earnings First 12 Months: Gross benefit + disability earnings up to 100% of indexed earnings After 12 Months: Gross benefit x percentage of lost earnings | |
| Return to Work Incentive | 10% of gross disability payment to maximum of \$1,000 per month | |
| RATES | | |
| Rate per \$100 Covered Payroll | \$0.46 | |
| Estimated Volume | | |
| Estimated Monthly Premium | | |
| Rate Guarantee | Expires 9/30/2018 | |

NAME OF CARRIER: _____

8. Please confirm any other applicable account fees, such as debit card fees, statement fees, balance transfers, etc...
9. Please confirm if City will have administrative rights to receive account information when necessary. Please detail what information is retrievable.
10. The City allows qualified participants the opportunity to fund their accounts via payroll deduction. Please confirm requirements for processing these deposits from a City account.
11. Please confirm account holders are able to request a transfer of funds from an HSA to a personal checking/savings account when qualified expenses are paid from a personal account and subject to reimbursement.
12. Please confirm vendor responsibility for tracking annual contributions. Should annual contributions exceed IRS limits, how is this addressed with the City and/or account holder?

Pharmacy

1. **Will you cover the cost of transferring existing mail order prescriptions from the incumbent carrier? If so, please provide file specifications for transfer of data. If not, please outline the Mail Order process.**
2. **Does your prescription drug proposal(s) include Step Therapy, Prior Authorization and Quantity Limits?**
3. **Does your prescription drug proposal(s) include an open or closed formulary?**
4. **Please outline your Specialty Drug process, including clinical support available to members, and if a third party vendor is involved in these transactions.**
5. **Provide a pharmacy disruption report identifying changes in tier, not covered prescriptions and/or utilization management program changes, for the attached historical pharmacy claims data.**
6. **Provide a copy of the proposed formulary.**
7. **Provide a list of standard drug exclusions.**
8. **Is insulin or other diabetic supplies such as glucometers, test strips, lancets, etc. considered under the pharmacy benefit proposed or subject to medical plan benefits? If subject to medical plan benefits, please confirm service category.**
9. **Is your pricing offer based on implementation of any new mandatory mail programs, clinical programs or plan design changes?**
10. **Does your prescription drug proposal(s) allow the client the right to accept or reject formulary content decisions that impact plan design?**
11. **Is proposer willing to grandfather existing users of a non-covered drug? If so, please confirm if indefinite or subject to a defined time period (i.e. 12 months).**

12. Is proposer willing to grandfather existing users of medications that require prior authorization (including specialty medications) without having to meet proposer's requirements?
13. What lead time do you provide to members when a drug is either removed from the formulary or moved to a different drug tier?