The following questions pertain to the Respondent's capabilities regarding the administration of the District’s vision insurance plan. You may supply supporting materials as required, but please provide your written answers to the questions below:

**General Information:**

1. Please list and describe your Florida public sector experience.
2. Define your cost auditing procedures and billing error incentives.
3. Please provide detailed information regarding the availability of your internet tools and system capability of on-line tools; internet capabilities; and provide examples of benefits and claims resources for members and administrators.
4. Please identify which of your networks are included in your proposal.
5. Do you allow Retirees under 65 and over age 65 to continue vision coverage under the same plan at the same rates as active employees?
6. Please describe your out-of-area coverage for retirees, dependent students or other dependents not residing with the employee (as a result of divorce or other reasons) but covered under their vision insurance plan.

**Customer Account Services:**

1. Provide the name, title, contact information and resume of the individual who would have direct daily account. If more than one person will be filling this role, please respond with complete information for all individuals.
2. Describe the services provided by your account service team to the employees.
3. Do you provide any additional, non-product related, Human Resources Support? Describe the services provided.
4. What is your account team service team’s average response time to client requests or questions?
5. Does your company help facilitate annual open enrollments?
   1. Onsite meetings?
   2. Educational materials?
   3. Printed materials at no cost?
6. Does your company assist with employee surveys? If so, provide a sample.

**Data and Reporting:**

1. Describe the reports you will provide regarding the utilization and claims associated with the vision insurance plan you are proposing. Please indicate in your description if any of the reports would be provided at an additional cost over the fees associated with the programs.
2. Provide copies of sample claims analysis reports.
3. Carriers are also asked to confirm that within each division listed above, the following classes can be broken out: Active, COBRA, Retirees 65+, Retirees -65, Spouses / Widows / Widowers.
4. What is your proposed frequency of reporting on utilization experience? Is there a charge for utilization data analysis?

**Renewal Planning & Additional Fees:**

1. Does your firm accept online payments or wired payments for premium invoices?
2. Are you willing to provide performance guarantees for implementation and servicing of your products? If so, please describe the performance guarantees you are proposing.
   1. If your company has forfeited funds because of service problems in the last three years, please list the three largest forfeitures by dollar amount and include the group name, group address, contact person and the telephone number where they may be reached.

**Benefit Administrator:**

1. Can your company accept eligibility via file transmission?
2. Does your company outsource the processing of electronic eligibility to a third-party? If so, please provide company name.
3. Please specify if your company (or third-party) accepts the HIPAA 834 v.5010 file layout as well as all other file layouts accepted for automated enrollment. Please provide applicable coding supplements and other applicable file specification documents.
4. Please provide requirements to establish a group as 'self-billed' including groups size, funding arrangements, etc.
5. What is your company's standard billing snapshot date and grace period for payment?

**Vision**

1. How does the proposed plan cover contact lens fit and follow-up examinations?
2. Is the materials copay applicable to contact lenses?
3. Please confirm if ophthalmologists are included as a part of the proposed vision network.
4. Describe the vision benefits in detail to include exclusions and limitations.
5. Please confirm dependent child(ren) eligibility.
6. Is the frequency for services (i.e., 12/12/24) based on the plan/calendar year or from date of last service?
7. Describe coverage for medically necessary contact lenses.
8. Include a schedule of benefits for contracted and non-contracted providers.
9. Include a price listing for lens options available to members. Please list the member’s responsibility.
10. Does the plan include conversion privileges if a member/spouse/dependent child loses group coverage? How do the benefits and rates differ from the group policy?
11. Provide an electronic network of providers and dispensing facilities for Sarasota, Manatee, Pinellas and Hillsborough counties.
12. Please provide a Geo Access report for Hernando, Hillsborough, Manatee, Pasco, Pinellas, Polk and Sarasota County as follows:
13. One Provider within 10 miles
14. Two Providers within 10 miles
15. Two Providers within 20 miles
16. Explain how Proposer’s network allows Members the flexibility to receive an exam (prescription) from one Provider and purchase materials (frames, lenses or contacts) from another.
17. Identify Proposer affiliations or any vested interest in optical laboratories, chain stores and retail optical stores; and describe how quality standard provisions for eyewear and optical laboratories are established by the Proposer.
18. Please outline all deviations from the current plan.