REQUEST FOR PROPOSALS

FOR

VISION CARE BENEFIT SERVICES

JUNE 17, 2024

For the City of Chicago
(the "City" or the "Lead Agency"),

the Chicago Park District (CPD), and

City Colleges of Chicago (CCC)

(which are sometimes referred to individually as an Agency or a Municipal Agency, and collectively as the Agencies or Municipal Agencies)

Email Address: Vision-RFP@cityofchicago.org

REQUEST FOR PROPOSALS (RFP)
VISION CARE BENEFIT SERVICES
SPECIFICATION #: CBO 2024-01

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SECTION I: RFP TIMELINE AND OTHER INFORMATION

A. RFP Release Date: June 17, 2024

RFP document, and associated Exhibits will be available at www.CityofChicago.org/benefits , and then "Other Resources", then "Request for Proposals". Addenda and responses to potential proposers' questions will be posted on the same site. Potential proposers are responsible for monitoring the website.

B. Pre-Proposal Submission Conference Date: June 25, 2024, at 10:00 a.m. Central Time

A pre-proposal submission conference will be hosted by the Agencies via video conference on June 25, 2024, at 10:00 a.m. Central Time. Participation is optional. The lead Agency will provide the video conference link to potential respondents that have registered. The details on how to register are set forth below.

C. RFP Responses Due Date: July 16, 2024, by no later than 4:00 p.m. Central Time.

Proposals are to be submitted prior to, but no later than the deadline above. Late proposals may not be accepted. Instructions on the required

D. Deadline to Submit RFP Written Questions: July 3, 2024, at 10:00 a.m. Central Time

E. Anticipated Contract Start Date: January 1, 2025, but may vary by Agency. The anticipated contract term is three years from the Contract Start Date with two options to renew the Contract, each option for a period of one year, but may vary by Agency.

F. Registration and Access to SharePoint Site

All the proposal documents must be provided via electronic files to a secure file-sharing system and one physical copy must be submitted. Instructions on where to submit the one physical copy of provided in Section VI: SUBMITTAL REQUIREMENTS

If your organization is submitting proposal documents, please send an email to: Vision-RFP@cityofchicago.org indicating your intent to submit proposal documents and provide the name and email contact for the individual who will be uploading the files to the secure site.

In a reasonable amount of time, the Lead Agency will provide the required registration and confidentiality statement forms that must be signed to participate in the pre-submittal conference, receive claims files, Microsoft Word and Excel versions of certain portions of this RFP, and other information, and be granted access to the Lead Agency's SharePoint site. The required registration and confidentiality statement forms must be signed by an authorized officer of the potential Proposer and delivered to the email address: Vision-RFP@cityofchicago.org.

If you fail to register following the process set forth above, you will not be provided with the electronic file, nor will you be provided access to the Lead Agency's SharePoint site. Entities that will not propose but that instead monitor RFP publication to inform potential Proposers shall self-identify, and in addition shall identify all the potential Proposers represented by the entity.

Proposers waive their right to have clarifications and/or addenda sent to them. The Lead Agency will endeavor to send to registered potential Proposers email notification of addenda to the RFP.

Nevertheless, those desiring to submit a proposal shall be responsible for checking the website for clarifications and/or addenda. Failure to obtain clarifications and/or addenda from the website shall not relieve Proposers from being bound by additional terms and conditions, clarifications, addenda, or from considering additional information contained therein in preparing proposals. Note that there may be multiple clarifications and/or addenda. Any harm to a Proposer resulting from failure to so monitor shall not be valid grounds for a protest against award(s) made under this solicitation. Failure on the part of the Proposer to receive any written addendum will not be grounds for any consideration including but not limited to extending any deadline, changes in or relaxation of any requirements of the RFP, or withdrawal of the RFP. Oral clarifications offered by any Agency or any representative or employee of any Agency will not be binding on the Lead Agency or any of the Agencies.

G. Communications:

Communications shall be through Vision-RFP@cityofchicago.org, the designated email address. Telephone or personal correspondence with any Agency regarding the RFP is prohibited and will receive no response.

Any revisions of this RFP deemed necessary by the Lead Agency will be made only by an addendum issued by the Lead Agency, posted on: www.cityofchicago.org/benefits, under "Other Resources" and then "Request for Proposals".

All questions regarding the RFP shall be submitted via e-mail by the deadline set forth above. In the subject line of any such email, identify the name of the Agency for which the question is intended if it is intended for fewer than all Agencies. Answers to questions received by the deadline will be posted on the website, and notification may be e-mailed to potential Proposers who have registered (but need not be as potential proposers are responsible for monitoring the website). Questions received after the deadline will not be answered.

SECTION II: GENERAL INVITATION

The Agencies (the City, CPD, and CCC), are a consortium of several local government and/or municipal entities with varying benefits for their employees (and in certain cases retirees) and their dependents (collectively "members" or "participants"). The Agencies request responses to provide the Vision Care Benefit Services specified in the Scope of Services and further described in each Agency's Agency Documents. The Agencies will accept proposals for Vision Care Benefit Services that are fully insured, self-insured, or both.

The tables below provide a brief overview of the vision care benefit services of the Agencies for 2023, a list of current vendors, and other relevant information.

If any Agency finds it necessary to continue receiving services from the incumbent vendor in order to comply with existing collective beginning agreements, the Agency reserves the right to continue to offer its vision care benefits through its current vendor for the term required under the collective bargaining agreement.

Current Vendor Name, Plan Type, Demographics & Financial Data,
(FI = Fully Insured, SI = Self Insured, MM=Million)

City Agency	Current Vendor	Plan Type	Covered Employees	Covered Lives (Including Employees and their dependents)	Covered Retirees	Covered Retiree Lives (Including Retirees and their dependents)	2023 Claims Processed	Cost of Service
City	Davis Vision	FI	29,186	69,995	3,563	7,761	22,288	$2.89 MM
CCC	VSP	SI	2,076	3,772	297	475	1,908	$0.28 MM
CPD	VSP	FI	1069	2204	9	27	723*	$114k

**Vision at CPD is voluntary, employee-pay-all.*

The Agencies are jointly requesting one proposal for all Agencies. Proposals shall not, however, include cross-subsidization of any Agency by higher rates or less favorable terms for another Agency. There is no guarantee that all Agencies will select the same Proposer.

Further, the Agencies reserve the right to: (i) select one or more Proposers to provide the services; (ii) reject any and all proposals; (iii) identify any areas where a conflict of interest may require limitations on a Proposer.

The selected Proposer shall perform the scope of services directly. Proposals submitted by brokers and by others not capable of directly performing the scope of services specified herein will not be accepted.

With respect to proposals for fully insured vision care benefits, if the Proposer is proposing to provide administrative services only but is not itself underwriting the insurance or administering the vision provider network and with respect to proposals for self-insured vision care benefits, if the Proposer is not itself administering the vision provider network, the following requirements apply:

- The Proposer must identify the insurer that will be underwriting the insurance and/or the administrator that will be administering the vision provider network.
- The Proposer must identify the corporate relationship (e.g., subsidiary, affiliate, etc.) and any common ownership as between the insurer and/or network administrator and the Proposer.

A firm may propose as a joint venture or independently as a single Proposer, but not as both. If a joint venture proposal is rejected, no firm which has participated in the joint proposal can be considered to provide services unless it has separately submitted a proposal. Similarly, two or more firms may submit proposals as a prime contractor(s) and subcontractor(s) relationship. In the event of such an arrangement, the Agencies reserve the right to reject any subcontractor and accept only the primary contractor. The Agencies will not accept a subcontractor and reject the primary contractor; if a subcontractor wishes to be considered separately for a portion of the services, it shall submit a separate proposal. A “partnership”, “joint venture” or “sole proprietorship” operating under an Assumed Name must be registered with the Illinois County in which located, as provided in the Assumed Business Name Act (805 ILCS 405.0.01, et. seq.).

The selected proposer will be required to enter into a separate contract or Professional Services Agreement with each individual Agency to provide the Services in accordance with terms and conditions acceptable to that Agency.

If an incumbent wishes to be considered for services under this RFP, the incumbent must submit a proposal. No automatic consideration for incumbents shall apply.

Termination of RFP: The Agencies reserve the right to terminate this RFP solicitation in part or in whole at any stage if the Agencies determine such action to be the Agencies’ best interest. The receipt of proposals or other related submittal documents will in no way obligate the Agencies to enter into any professional services agreement or contract of any kind with any party.

Contracting: The selected Proposer shall perform its services in accordance with the terms and conditions of an insurance contract (policy) issued to an Agency or a written contract (Professional Services Agreement) entered between the Proposer and an individual Agency, in either case pursuant to negotiations between the Proposer and that Agency.

With respect to an insured benefit, an individual Agency may require both an insurance contract (policy) and a Professional Services Agreement between the Agency and the Proposer incorporating any required services or terms not included in the policy of insurance. In such case, the Professional Services Agreement shall meet the minimum requirements for the services described in this RFP, and shall include, if any, additional enhancements offered in the selected Proposer's proposal or required by the Agency. In no event will an Agency enter into any Professional Services Agreement or contract offering fewer services than required by this RFP or at greater costs than offered in the selected Proposer's proposal or as the proposal is modified through subsequent submissions to the Agencies. A selection of a Proposer to provide services pursuant to this RFP is contingent upon the Proposer and the Agency timely agreeing on contractual terms. Agencies unable to successfully negotiate a contract or Professional Services Agreement with the selected Proposer may decide to terminate further negotiations with such Proposer and elect to commence negotiations with the next most qualified candidate.

Terminology: The terms used in this RFP shall have the meaning assigned to them by the respective Agencies' benefit plans, unless defined differently in context.

SECTION III: SCOPE OF SERVICES

This Section will be provided in Microsoft Word to potential Proposers who register as provided in Section I.

Your response shall include a copy of the Scope of Services, with your responses to the Scope of Services. In each case, the Proposer shall answer whether Proposer will satisfy the below requirements. The proposer shall answer “yes” or “no.” If the answer is no, or is neither yes nor no, include a cross reference to a footnote or separate page in which you explain your response. The electronic copy of your response must be submitted in Microsoft Word, and in your response the scope paragraph requirement (the left column) shall not be reworded, deleted, or changed in any way. If an answer is “no,” Proposer shall explain in a separate page at the end of the responses to the Scope, and/or propose alternate wording to the Scope item such that the Proposer would respond “yes.”

Merely because a requirement is not set forth in the Scope of Services does not mean the requirement does not exist; this Scope of Services is not exhaustive. It is supplemented in all cases by the Agency Exhibits, and the Agencies reserve the right to add additional requirements to the Scope of Services as necessary or as collectively bargained.

In the response to the RFP, each Respondent shall assert in writing that they meet the requirements 1-10 listed below. Each Respondent shall also respond to the Vision Care Benefit Services, Scope of Services table listed directly following requirements 1-10.

1. The Proposer has at least five years of expertise in providing Vision Care Benefit Services to be procured through this RFP.
2. The Proposer has annual gross revenues during either 2022 or 2023 of at least $100 million.
3. The Proposer is licensed in the State of Illinois and has other licenses and certifications as may be necessary to provide the proposed vision services.
4. The Proposer has current and on-going accounts of comparable types of programs, including public sector employers and labor union organizations.
5. The Proposer provides Vision Care Benefit Services to at least three accounts with at least 25,000 employees per account in which the majority of employees’ employment is the subject of collective bargaining agreements.
6. The Proposer will provide information on the number, name, and size of clients acquired and lost during the last three years and a listing of at least three relevant references.
7. The Proposer will provide job descriptions for each key position and the names and resumes of each person who will serve in such positions. List qualifications and include his/her experience with public sector employers.
8. The Proposer has strong and effective security and HIPPA and cyber-security privacy practices and procedures, as required by applicable federal and state law. Proposer will periodically perform and document a risk/threat analysis to identify high risks threats and implement necessary mitigation measures.

9. The Agencies are soliciting proposals and rate quotations for Vision Care Benefit Services in accordance with the attached Agency Exhibits. Proposals are solicited on either an administrative service only (ASO) (self-insured) basis or fully insured basis, or both, unless otherwise indicated by the Agency. Do you agree to submit proposal(s) that: Permit employees and their dependents to obtain comprehensive, professional vision care services that are easily accessible and provided in accordance with the terms of the Agency Exhibits? Do you agree to ensure that the programs are administered effectively, efficiently, and responsibly at the lowest possible cost to the Agencies and their employees and covered dependents?
10. Proposer shall review each Agency's Agency Exhibits and make an affirmative statement regarding administration of each of them, including the ability to administer the exclusions to coverage and all other benefits.

VISION CARE BENEFIT SERVICES SCOPE OF SERVICES	YES/NO/NEITHER
A. Proposer shall perform services in compliance with the Vision Care Benefit Services (also referred to as Plan) of each Agency.	
B. Proposer shall offer such services in conformance with federal and state laws, regulations and ordinances, and in accordance with the personnel policies, procedures and rules of each individual Agency.	
C. Proposer shall only offer services by persons or organizations authorized and duly licensed by the appropriate regulatory agencies when such licensing or authorization is required.	
D. Proposer shall provide claim and eligibility files to an Agency's selected service providers in a frequency and manner to be determined jointly by the other service provider and the Proposer.	
E. Proposer shall specifically represent and warrant that all participating providers in the Proposer's network meet the Proposer's credentialing requirements and that an ongoing quality assurance program is maintained.	
F. Proposer shall ensure that any participating providers in the Proposer's network shall be appropriately licensed, insured, and of high quality; and that they meet all other requirements specified by the Proposer.	
G. Proposer shall specifically represent and warrant that facilities and professional providers of services shall be insured at a minimum by the amounts and kinds of insurance specified herein by each Agency, if specified by the Agency in its Agency Exhibits.	
H. Proposer shall perform its services directly. For example, proposals by brokers not capable of directly performing the services specified herein shall be deemed non-responsive.	
I. Proposer shall review and advise the Agencies regarding the Plan designs set forth in the Agency exhibits.	
J. Proposer shall promptly advise the Agencies of all present or future changes or pending proposed legislative changes that may affect coverage provided under the Agency's Vision Care Benefit Services or the operations, financing, administration, or terms thereof. Proposer is not expected to provide legal advice to the Agencies.	

VISION CARE BENEFIT SERVICES SCOPE OF SERVICES	YES/NO/NEITHER
K. Proposer shall perform all administrative functions necessary to ensure appropriate financial controls.	
L. Proposer shall reimburse the Agency for claims paid in error whether or not Proposer has recovered payment from claimant (for self-funded benefits) and will remove said claims from the experience of the Agency to the extent that the Agency is fully or partially insured, if it is determined that Plan coverage has been provided to an individual or individuals ineligible for coverage or that benefits have otherwise been paid in error.	
M. Proposer shall receive, maintain, and process the participant and dependent eligibility files: (i) in an accurate and timely manner, and (ii) have the capability to use an Agency provided computer file, via electronic transmission (transmission (not tapes, disks or CDs) and in a format and time frame to be determined between the Agency and the selected Proposer, Further, and (iii) Proposer shall be able to maintain eligibility at the dependent level	
N. Proposer shall have the capability of allowing the Agencies to manually enroll, disenroll, and update participant information via a secure online portal.	
O. Proposer shall have the ability to accept a positive notice of termination at the dependent level (i.e. Proposer shall not require "term by absence" from the data file).	
P. Proposer shall maintain confidentiality of participants and Agency records in accordance with Agency standards, and all applicable laws and regulations. This confidential information, including personal data and demographics derived, may not be used by the selected Proposer for purposes not related to providing services under its contract with an Agency and may not be sold, marketed, furnished or otherwise made available to others for any purpose unless specifically directed by the Agency in writing to do so.	

VISION CARE BENEFIT SERVICES SCOPE OF SERVICES	YES/NO/NEITHER
Q. With respect to insured benefits, if the Proposer is not itself underwriting the insurance or administering the vision provider network, the Proposer may not share confidential participant/Agency records and information with the insurance carrier or network administrator, unless such insurance carrier or network administrator agrees to be bound by the confidentiality requirements set forth in the contract between the Proposer and the Agency, and the Proposer agrees to accept full liability for and indemnify the Agency in the event of breach of confidentiality by the insurance carrier or network administrator.	
R. In particular, but without limitation, Proposer and any separate insurance carrier and/or network administrator as well as any subcontractor thereof may not use confidential information for purposes of (i) business research or (ii) marketing or selling services or products to participants.	
S. Proposer shall acknowledge that all records are the property of the Agency and shall be returned to the Agency upon the completion or termination of the contract, including any such records in the possession of an insurance carrier or network administrator.	
T. Proposer shall permit periodic audits by Agency staff or Agency appointed auditors, of the work performed in the administration of Vision Care Benefits Services on behalf of the Agencies.	
U. Proposer shall promptly rectify errors and resolve disputes in a manner satisfactory to the Agency.	
V. Proposer shall comply with the MBE/WBE requirements of each Agency as set forth in this RFP.	
W. Proposer shall complete the disclosure documents pertaining to each individual Agency as set forth in the Agency Exhibits (Documents vary by Agency: e.g., the Economic Disclosure Statement, Contractor Disclosure Form, Contractor's Disclosure Affidavit, Disclosure of Retained Parties, etc.) and to promptly update such documents when any material aspect of the submitted disclosures change.	

VISION CARE BENEFIT SERVICES SCOPE OF SERVICES	YES/NO/NEITHER
X. Proposer shall develop employee communication brochures, pamphlets, and materials, subject to the Agency’s approval, which the Agency considers necessary to communicate the benefits of the Plan. The development, production and distribution of materials shall be at no cost to the Agency. Proposer is responsible for the accuracy, completeness and compliance with all legal requirements of the materials. Proposer shall provide required notifications to employees on a timely basis at no cost to the Agencies. Neither Proposer nor the insurance carrier or network administrator (if separate) or any subcontractor thereof shall send employee communications (other than communications with respect to benefit claims and appeals, such as explanations of benefits) without the approval of the Agency.	
Y. Proposer shall assist the Agency in the drafting and review of revisions to Vision Care Benefit Services documents and summaries. For an insured benefit, Proposer will provide a Certificate of Benefits that can be posted on the Agency’s web-site and/or paper copies for distribution to participants as required by an individual Agency. Any such Certificate of Benefits must accurately reflect the benefits to be provided under the Agency’s Plan and eligibility therefor and shall provide benefits for any individual determined to be eligible by the applicable Agency.	
Z. Proposer shall offer participants appropriate web-based applications, as well as apps for online mobile devices, that include Vision Care Benefit Services design information, eligibility information, provider network information, cost comparison tools (if appropriate), key contacts, and other information pertinent to the services offered, and that allow participants to request identification cards if such cards are needed to access services.	
AA. Proposer shall undertake all other necessary tasks to properly administer the Services, including but not limited to, recording eligibility based upon the Agency provided eligibility information, sending I.D. cards (if such cards are needed to access services), communications and brochures to employees, responding to telephone inquiries, claims, and appeals, directing employees to the appropriate use of Plan benefits, and, with respect to a self-insured benefit, paying claims (with funds provided by the Agency).	
BB. Proposer shall provide, at no cost to the Agencies, training materials and on-site training sessions necessary for implementing the Plan benefits.	

VISION CARE BENEFIT SERVICES SCOPE OF SERVICES	YES/NO/NEITHER
CC. Proposer shall provide the Agencies with management information reports on a monthly and quarterly basis or access to the same or similar reports through a client facing reporting tool.	
DD. Proposer shall also provide management information reports as requested by the Agency. See Interrogatives, Reporting Requirements, which outlines minimum reporting criteria. The Agencies reserve the right to make changes in the content and frequency of reporting requirements.	
EE. Proposer shall also provide reporting requested by the Agency on an ad hoc basis for collective bargaining purposes and, if requested by the Agency, shall participate in collective bargaining sessions as an expert source for the particular benefit.	
FF. Proposer shall attend open enrollment or special enrollment meetings as required. The Agencies will be reasonable in their requests for attendance at such meetings. However, the Proposer shall acknowledge that many of the Agencies have multiple work sites and that certain employees work non-standard hours in locations that span the City.	
GG. Proposer shall provide participants and the Agency with prompt, accurate and courteous service. Timely service specifically includes prompt issuance of identification cards (if such cards are needed to access services). Each Agency reserves the right to provide the selected Proposer with its own custom generated set of unique identification numbers.	
HH. Proposer shall ensure that any participating providers meet all other requirements specified in this RFP.	
II. Proposer shall provide toll free telephone service adequate for member satisfaction and adequate for provider access, and not less than ten hours per day on weekdays and six hours per day on Saturdays.	
JJ. Proposer shall provide specified services without regard to any waiting period.	
KK. Proposer shall provide specified services without regard to any pre-existing condition.	

VISION CARE BENEFIT SERVICES SCOPE OF SERVICES	YES/NO/NEITHER
LL. Proposer shall provide continuation coverage in accordance with each Agency's continuation of coverage programs, including but not limited to each Agency's policies with respect to employees who are on inactive status due to family or medical leave of absence, ordinary leave of absence, suspension, Workers' Compensation, pension disability, personal disability, or a temporary lay-off.	
MM. Proposer shall attend Agency health and wellness fairs at no additional cost	
NN. Proposer shall work cooperatively and diligently with an Agency to achieve its goals for its benefit programs.	
OO. Proposer shall specifically acknowledge that it understands the limits of the collective bargaining process and that in offering to provide services, it will not demand or otherwise attempt to change any Plan provision without the approval of the impacted Agency.	
PP. Proposer shall acknowledge that it prepared its pricing proposal with full knowledge of the limits of the collective bargaining process which will not allow for Plan provision changes without bargaining.	
QQ. Proposer shall represent and warrant to the Agency that it is adequately staffed and ready, willing and able to provide the requested services in a professional, highly competent manner.	
RR. Proposer must agree that it understands that the Agencies will substantially rely on Proposer's statements and representations provided in its response to the RFP and subsequent submissions to the Agencies during the RFP process.	
SS. Proposer shall work creatively and cooperatively with each Agency to ensure that the benefit program offers good value to the Agency and its Plan members.	
TT. Proposer shall include in its cost proposal an offer to underwrite a portion of, or all of, the cost of any computer programming or systems development on an Agency's benefits management information system, or that of its benefits management outsourced vendor, that is necessary to implement the services being proposed.	

VISION CARE BENEFIT SERVICES SCOPE OF SERVICES	YES/NO/NEITHER
UU. Proposer shall propose an initial contract term of at least three years. Proposer may propose an initial contract term of five years. The cost of an initial term shall be stable for the duration of the initial term.	
VV. Proposer shall propose two renewal terms of one year each, exercisable at the unilateral option of an Agency, the cost of which may be proposed to differ from the initial contract term but must be specified in the proposal. Proposer may propose a third such renewal term.	
WW. Proposer shall propose that it will provide all renewal information including costs, benefit levels, etc. to an Agency at least 120 days prior to the expiration date of any contract period.	
XX. Proposer shall propose that an Agency, by written notice given prior to the expiration of the then current term of the agreement with the Proposer, may exercise its renewal option.	
YY. Proposer shall provide the services at a cost most advantageous to the Agency and its members.	
ZZ. Proposer shall acknowledge that any contract executed by an individual Agency with the selected Proposer may be subject to and contain mandatory terms and conditions. The terms and conditions may include the terms and conditions set forth in the Agency Exhibit for that Agency, although the precise language and detail may differ. Nothing here represents a restriction on an Agency or prevents an Agency from requiring fewer, different or additional terms and conditions in the contract. At the option of the Agency, for an insured benefit, there may also be a Professional Services Agreement between the Agency and the Proposer incorporating any required services or terms not included in the policy of insurance.	
AAA. Proposer shall propose to provide data files to the Agency, upon request, of claims, and if applicable, enrollment data in a frequency no less than monthly.	

SECTION IV: INTERROGATIVES

This section will be provided in Microsoft Word to potential Proposers who register as specified in Section I.

The Agencies have various vision care benefit packages. Benefit designs may vary and may include an annual eye exam, with or without co-payment, materials or discounted materials, and other combinations of co-payments and/or discounts. Note that one agency offers vision coverage on an "employee pay all" basis.

Respond to each interrogative below.

General

1. Provide the full name and address of your company (headquarters) and the address(es) of your Chicago metropolitan area offices or the address of the location from which the Agency accounts would be administered.
2. What year was your company founded?
3. Describe the organization (organizational structure and lines of supervision) and capitalization of your company, listing all principal owners and shareholders and the percentage (if any) of ownership interest held by a corporation or other legal entity, including its relationship to you, and identify your company's subsidiaries.
4. Is your organization, including but not limited to the parent company, a subsidiary or division of your company or any officer involved in any litigation that could affect its ability to meet the requirements as stated in this RFP? Are there any planned or pending agreements or negotiations to merge or sell your company? If yes, include agreements, letters of intent, or comparable documents pertaining to such agreements or negotiations.
5. Describe your organization's financial stability.
6. Submit your three most recent annual financial stability ratings (e.g. Best's, Moody's, Standard & Poor's).
7. If you are offering an insured proposal, are you in compliance with all requirements of the insurance laws and the requirements of the duly constituted insurance regulatory authority of the State of Illinois or any other state in which your company operates? Please specify.
8. If you are offering an insured proposal, provide the full name and address of the insurance company (headquarters) that will be underwriting the insurance, if different from your company.
9. Do you now or have you ever had a contract with any of the Agencies to provide any product or services? If so, list each such contract identifying the start and stop dates and the product or service offered to the specified Agency.
10. Is your organization currently engaged in or do you have any pending service contracts which may result in a conflict of interest with any of the Agencies? If yes, describe the potential or actual conflict of interest.
11. Has any part of your company including, but not limited to, the parent company, a subsidiary or division of your company or any officer filed for bankruptcy or

reorganization within the last five years? If yes, provide pertinent details of these actions.

12. Describe your commitment to the public employee market.
13. What is your organization doing to create value in vision care benefit services for employer sponsored plans?
14. What are your profit goals for the next four years?
15. How many of your employees, if any, work within the City of Chicago? How many if any, reside within the City of Chicago?
16. What is it about your programs and services that distinguishes you from other vision care service providers? What is unique about your offerings? What critical advantages do you have that other vendors do not?

Service Delivery Experience

1. How long have you been providing Vision Care Benefit Services?
2. How many employer groups currently utilize your Vision Care Benefit Services? How many of those employer groups are in the Chicago metropolitan are?
3. What benefits are unique to your organization and how do you differ from your competitors? What value is added by a relationship the Agencies would have with your organization?
4. What was the total enrollment for the Vision Care Benefits Services on January 1 for each of these three years: 2022, 2023, and 2024:
    a. In the metropolitan Chicago area, provide both the number of employees and the total number of covered lives.
    b. In Illinois, provide both the number of employees and the total number of covered lives.
5. What is the projected enrollment for 2025? Provide both the projected number of employees and the total number of covered lives.
6. Indicate for what period of time this proposal is binding. (The period must be no less than 12-months.)
7. What is the total number of employee lives and covered lives in your programs?
    a. Private pay individual
    b. Employer groups
    c. For your five largest employer groups, indicate clients with:
        i. employee population greater than 25,000
        ii. employee population greater than 25,000 with collective bargaining agreements
8. Name the five largest accounts that have not renewed their contracts over the last three years. Provide the following:
    a. An explanation as to why they did not renew
    b. Names, addresses and telephone numbers of contacts
    c. Number of eligible employees
    d. Number of employees enrolled
9. For your five largest employer groups list the following:
    a. Anniversary date
    b. Current rates, if applicable, announced future rates

c. Total enrollment for each group
d. Difference in benefits from those proposed to be provided to the Agencies
e. Contractual period
f. References, with phone numbers, for each of these groups

10. Indicate the number of people you employ in each of the following areas:
    a. Claims processing
    b. Provider relations/management
    c. Information technology function commonly known as “systems”
    d. Customer service/eligibility units
    e. Quality assurance
11. Quality Based Plan Design – There are 3 vision plan designs, one for each Agency, set forth in each Agency’s Agency Exhibit. Note that the City’s Vision Plan Design has two components, one for Plan A-LMCC and the other for Plan B-FOP. Please provide a response to this interrogative for each Agency.

    The Agencies’ collectively bargained plan designs may or may not be revised in future collective bargaining. Proposers shall review the existing Vison Plan designs and A) propose any changes that may be appropriate to promote healthy outcomes and quality benefits consistent with prudent employer and employee expenditures of financial resources, including but not limited to recommended incentives if any, and B) provide an estimate of the improvements in healthy outcomes and the financial savings related to such proposals. In particular, please review the existing Vision Care Benefit Services (Plans) and make recommendations for changes that would:
    a. Improve participation in other wellness and chronic disease programs
    b. Improve the vision health and wellness of the population
    c. Encourage ownership of personal vision health
    d. Appropriately balance employer and employee spending
    e. Suppress or reduce trend
    f. Produce desired results within three years

    Quantify any increased expenses or cost reductions associated with your recommendations. Provide examples of employers who have adopted similar strategies and provide an estimate of results that might be obtained if your recommended strategy were adopted. You may suggest phased changes if such are appropriate.

Administration and Operations

1. Provide an organizational chart of the administrative and medical management of that part of your organization that will provide Vision Care Benefit Services. Also, provide a description of the resources the organization expects to commit to in order to perform the services required. Include the expected staffing levels to be utilized and number of full-time equivalent employees.
2. Discuss how your organization would implement the addition of a significant number of new employees and dependents to your client base. Include in your statement how you will transition this group from the existing vendor to your organization, if your organization is selected. Be specific as to what data you would require from the current insurance carrier(s)/administrator(s)/service provider(s) to assure a smooth transition.

3. Provide a detailed timetable (Gantt Chart) geared toward a January 1, 2025, implementation date, indicating the earliest completion dates your organization would be able to implement all significant tasks. This timetable must serve as an actual work plan and must include, but not be limited to:
    a. Initial planning meeting
    b. Coordination with Agency staff
    c. Customer service training
    d. Communications development and production
    e. Network development
    f. Development of systems capabilities
    g. Contract development and execution
    h. Answer the following 2 questions:
        i. How will you assign unique ID numbers (if any).
        ii. How will you produce and issue Enrollment (membership) cards (if any) prior to commencement of provision of services; and
4. Provide the following sample forms and or standard materials used in administering the Vision Care Benefit Services: Member Explanation of Benefits (EOBs); invoices and backup documentation sufficient for your customer to verify the accuracy of the invoice. Provide a list of all EOB messages.
5. For self insured proposals, please confirm that you will provide a claim file with the invoice for services (the file to be in a format mutually agreeable to the Agencies and the selected proposer.)
6. If you provide identification cards for members, how are they created and distributed? What constitutes the employee member number? Will you pay all costs associated with identification card distribution? If not, why not? Can the ID card be customized with a logo/seal?
7. The Chicago Park District's plan is a fully insured, employee-pay-all program. The Park District requires a payroll deduction file and an eligibility file of employees and dependents. Confirm you propose to meet those requirements.

Customer Support Services

1. What are your general business hours?
2. What are the hours of your customer service department? Where is your customer service department (function) located?
3. Do you have a toll-free phone number? Do you propose a separate toll-free number for each Agency? Is there an automated attendant? If so, how many choices is the caller offered via the automated attendant? Will you allow an agency to customize the automated attendant?
4. Describe the telephone system and workflows.
5. Do you offer separate phone numbers for providers and members?
6. How many people are available to answer telephone calls during your hours of operation?
7. Describe your customer service representative training program.
8. Describe the minimum qualifications, including educational credentials for selection as a customer service representative.

9. Describe your customer service department, including the role and responsibilities of the customer service representatives.
10. How will employees be notified of changes to the provider network?
11. Do you have a website for enrollee inquiries? If you have a test site or "test ID" that the Agencies can use to review your website, please provide a list of user IDs and passwords. Please include screenshots of the five most used functions of your web-based and/or mobile apps. Of your customer base, how many unique individuals use your electronic services such as a website or mobile app, instead of telephoning?
12. How do you ensure the privacy of member information?
13. How do you educate new members about the availability of member facing web opportunities?
14. Do you have a cell phone text message function, an iPhone, Android or other smart phone app? If so, how do you ensure privacy?
15. Describe how and when you communicate to members about available programs and services. Do you have an annual communication plan? Do your member communications only go to members registered on your participant applications? Do you mail any communications other than paper EOBs? If yes, describe the content and circumstances under which your firm would distribute these mailings.
16. On average, how many formal complaints and appeals per 1,000 members are filed by members?
17. What were the two most common areas reflected in those complaints?
18. Describe your system for tracking inquiries, complaints, and appeals. What are your standards for follow-up and resolution? What is the percentage of inquiries and complaints that become appeals? What percentage of appeals is resolved in favor of the Plan member? What percentage of appeals involve providers?
19. Describe the grievance procedures in detail for the enrollees and the provider and any role the Proposer or provider would expect the Agencies to take in the process. Indicate under what conditions a member could be terminated from coverage. What means of appeal are available to the member?
20. Provide the following statistics:
    a. Number of grievances submitted in each of the past two years.
    b. Subjects of the grievances (e.g., provider courtesy, quality of care, access to specialty care, claim denial); and
    c. Results of grievances by subject:
        i. denial upheld
        ii. denial modified
        iii. denial overturned
        iv. other
21. Provide a statement of how your company expects to resolve:
    a. Employee complaints;
    b. Provider complaints; and
    c. Agency complaints.
22. How does your organization monitor enrollee satisfaction regarding promptness, courteousness, and accuracy?
23. Provide the results of any member surveys conducted over the past two years.

24. Do your web-based apps/portals have a "chat" function to resolve claim inquiries?

Provider Network Management

1. Do you currently have an operational provider network in the Chicago metropolitan area? If so, describe the provider network in detail, and provide a map indicating the locations of the facilities and providers.
2. If you are not the network administrator, due to utilization of a leased network or for any other reason, provide the name, address, and contact information for the entity that administers the network and describe your corporate relationship (if any) with such entity.
3. When was the vision service network you are offering first effective?
4. For what reasons can the network terminate agreements with providers?
5. Describe how a participant that requires vision care services while outside of the metropolitan Chicago area will be provided services. Example: a dependent who requires care over an extended period while away from home (e.g. a student attending college). Do you have "guest" or "visitor" status programs for people who are temporarily domiciled outside of the service area (including while out of the country)? What are the terms and conditions of such programs?
6. Describe what procedures will be used to ensure that the services offered to Agency employees and their dependents are of high quality. Describe in detail the selection procedures for becoming a participating ophthalmologist or optometrist in your vision care network.
7. Some Agencies have retirees located outside of metropolitan Chicago and outside of Illinois for whom they must provide vision benefits. If you do not have a nationwide network, how will you ensure that these out of area participants receive good quality services at a fair price?
8. If your network is not a good match for the existing network, what steps will you take to ensure that you add providers so as to reduce disruption?
9. How many optometrists are in your network? How many ophthalmologists? Under what circumstances may a participant visit an ophthalmologist for no additional charge?
10. Do you have any pediatric ophthalmologists in your network?
11. Do you develop utilization profiles for your providers? If so, how do you use profile data to ensure appropriate treatment?
12. Explain how the service providers are compensated (e.g., salaried, fee for service, capitation, risk pool, administrative services only (ASO) or other arrangements).
13. How do you ensure that the optometrists in the network are financially solvent and remain so?
14. For the last twenty-four months of operation:
    a. how many providers have you added to your network?
    b. How many have voluntarily stopped participation?
    c. How many have you removed from your network, and for what reasons have you done so?

17. What insurance coverage (amount and type) do you require providers to maintain and how do you verify that this coverage is continually in force? Are you an additional insured? Do you have umbrella coverage? What amount?

Vision Materials and Production of Vision Materials

1. Can in-network providers use their own laboratories? If the vision care service provider does not have a laboratory, is the provider able to select the laboratory of its choice for vision materials or must they use a specific laboratory assigned by your company?
2. If in-network providers must use a specific laboratory, by which entity is the laboratory owned? What is the business relationship of the assigned laboratory and the Proposer? Quantify any revenue you may receive from this relationship.
3. Describe your selection criteria and on-going quality monitoring procedures for laboratories.
4. With respect to frames, what frames are available at no cost to employees and dependents? How are such frames selected? What is the average retail and wholesale cost of such frames? How would a credit for the no cost frame be applied to a more expensive frame?
5. Provide specific examples of how a more expensive frame and/or lens treatments would be charged to the participant.
6. If you use retail cost rather than wholesale cost, provide a comparison that illustrates both retail and wholesale cost for a sample of frames that are above the “standard” cost reflected in your proposal. For this purpose, report on the ten most popular frames in your book of business that are not part of your “standard” package of frames (frames for which there is no additional cost to the participant). Provide a specific reference as to your source of data (date and source) for wholesale pricing.
7. If you are able to do so, provide a sample of the ten most popular frames available for participants at no additional charge. Please include a return mail label so that the frames can be returned to you at the end of the RFP process. One physical sample is sufficient for this purpose. Please mark the box or other container clearly as "SAMPLE FRAMES FOR REVIEW BY THE AGENCIES." Deliver this sample with the physical proposal submission (see Section VI, Submittal Requirements, below).
8. If the Proposer expects to directly or through a subcontractor relationship manufacture lenses, and or glasses, include a list of such vision laboratories with a listing of services provided by each laboratory.
9. What options do you offer for contact lens benefit? Do you require network providers to use a standard pricing list for contact lens? Why or why not?
10. What type, brands and number of contact lenses are available for no additional cost based on the proposed material/benefit allowances? Specificity is appreciated.

Services Provided to Plan Members at Network Provider Locations

1. Describe through narrative and a flow chart how network services are provided to eligible persons from the point of calling for an appointment through in-office delivery of materials.
2. Do you have any special or different programs for those persons with chronic conditions that may involve frequent vision changes or may need more frequent examinations? If

so, for what conditions would you recommend that an Agency consider offering more frequent access to eye exams or materials?

3. How do you ensure that optometrists and or other vision care providers are charging the correct co-payments? Provide the schedule of employee co-payments by procedure code that will be charged by network providers.
4. For those services that are not covered by the Plan but are offered by an in-network vision care provider, do you limit the amount a network provider may charge?
5. If you require that providers maintain standard hours of operation, please indicate those hours.
6. Some of the Agencies expect that employees and dependents that use network providers will be able to receive an exam and basic services with no out-of-pocket cost in some cases or at significant discounts in other cases. See Agency Exhibits for details. Are you able to offer benefits under these various terms? Be specific as to any exceptions.
7. What are the components of the optical exam provided to Plan members? What tests are performed in a standard examination?
8. Are retinal images/digital fundus photos included for the standard rate? If no, how much extra cost is charged for this service?
9. Do you as the Vision Care Benefits Service Plan provider recommend any tests or services in addition to the standard tests in the optical exam? If so, what tests or services? At what cost to the participant?
10. Do you offer guidance to participating providers on what tests should be offered and with what frequency? Do the frequency of tests or the content of the initial exam visit differ by patient age, gender or disease status?
11. What are your minimum standards for record keeping for your providers?
12. If additional costs to members are expected beyond the exam fee and the materials and/or contract benefit, describe those costs and how they are determined. Does the Vision Care Benefits Plan Service Provider determine the amounts or are the amounts set at the discretion of the individual providers in the network? Does the Vision Care Benefits Plan Services Provider evaluate the reasonableness of the amounts charged to members?
13. For benefit plans similar to the Plan offered by each Agency, what is the typical out of pocket cost a participant will pay for the combination of exam and materials, based on your book of business data in the Chicagoland area? For an adult? For a child?
14. For your book of business, based on each Agency's Plan, how many members or what percentage of members who are issued glasses would be able to receive a pair of glasses at no additional cost to the member? For those who are not able to receive the pair of glasses without additional cost, what is the average cost you would expect a member to pay (again, based on the experiences of persons with coverage similar to the Agency benefit Plans)?
15. For lens treatments (e.g. plastic coating, multi-focal lens) do you require your network providers to use a standard pricing list? Why or why not? Are network providers required to limit a patient's out of pocket expense for such services?
16. Do you offer a surgical vision correction program, for example Lasik or other similar techniques? Do you offer a network of providers for a discounted price? If yes, what

would be the price and how would participants be informed of the network? If you offer such a program describe the program in detail.

Provider Compensation

1. Provide a sample Vision Care Benefit Services provider contract.
2. On what basis are vision care service providers compensated?
3. Do network providers pay your organization to be part of your network? If yes, explain in detail.
4. Are there any programs where you retain a % of savings (e.g. rental network usage). Provide details on each program and compensation arrangement.
5. For the provider's total compensation for a single patient who avails themselves of the materials benefit, what percentage would you expect comes from the plan and what percentage comes from patient revenue?
6. Do you maintain statistics on patient out-of-pocket expense? What percentage of patient's would you expect to be able to have zero out-of-pocket expense for materials based on each Agency's Plan of benefits? (Provide a separate answer for each Agency based on their current Plan designs.)
7. Is any part of Vision Care Benefit Service provider compensation based on consumer satisfaction? If yes, describe criteria used to measure satisfaction. If not, why not? Provide the appropriate measurement criteria for other compensation factors.
8. Is any part of provider compensation on patient outcomes related to the vision care benefit services provided to the participant? If yes, describe criteria used to measure outcomes. If not, why not?
9. What aspects of vision care service delivery do you believe are relevant to patients? Do your contracts reflect or require any of those items you believe relevant to patient satisfaction? If yes, describe. If no, why not?
10. Do you allow providers with whom you contract to benefit from your contracts with other providers? For example, if you had a contracted relationship with a lens manufacturer and a vision care service provider did not have such a contract, could the vision care service provider take advantage of any discounts or price reductions under your contract?
11. Are any vision care benefit services providers paid on a basis other than fee-for-service? If yes, please describe such arrangements. How do you evaluate the cost efficiency of contracted providers?

Credentialing

1. Describe your provider selection criteria. What criteria are used to recruit, select and credential providers?
2. Do you credential providers in accordance with National Committee for Quality Assurance (NCQA) standards?
3. Do you have a process for re-credentialing providers? Describe in detail.
4. Do you conduct on-site evaluations? Do you verify state licensure with primary sources; current malpractice insurance coverage and claim history?

5. How often is malpractice insurance information for individual vision care service providers verified?
6. Do you credential opticians differently than you credential optometrists and ophthalmologists? Please explain.
7. How do you evaluate vision care service provider performance? Describe your evaluation process. Have you established minimum performance standards?
8. Do you maintain a corrective action process for providers identified as being poor or sub-standard vision care service providers? How does it operate? How many providers have been terminated for poor performance?

Claims Administration

1. Which claim payment functions have you delegated to vision care service providers? For which services? How is information shared between the providers and your claim systems?
2. For those functions which you have delegated, how do you ensure accuracy and timeliness of service?
3. Describe your organization's experience processing claims for large-sized clients. Describe policies and procedures for processing claims and handling customer and provider inquiries on claims. Provide a flow chart diagramming how claims will be processed including control procedures, estimated time frames from initial receipt of a claim through pending, final resolution, issuance and mailing of payment and/or explanation of benefits ("EOB").
4. What percentage of your claims are filed electronically? What percentage of your claims are adjudicated electronically? What percentage of claims are routed to claim staff for further consideration?
5. How do you define errors in claim payments? Do you have an on-line documentation system to monitor and track inquiries for both individual follow-up and closure as well as trend analysis over time? How will you ensure that the claim payment for the treatment of a given medical condition represents payment of the least costly, effective form of treatment? Explain. Will you allow the Agencies to recover based on extrapolation from the results of an audit?
6. Provide the guidelines you use for determining Reasonable and Customary ("R&C") charges for providers who are not in your network. How often are these R&C files updated? What is the data source for these amounts? For insured proposals, provide a copy of the language you have filed with the State of Illinois for out-of-network payment levels. If you believe R&C determination for non-network providers is not relevant to vision care benefit services, explain.
7. If a claim is received with missing information, explain how such a claim will be handled. What information (or lack of information) on a paper claim form would delay payment? What steps do you take to obtain missing information (provide a sample of the currently used forms or form letters mailed to members eliciting additional information when submitted claim forms are inadequate for adjudication)? What percentage of your paper claims are delayed because of missing information?

8. What is your average days claim inventory? Indicate number of working days.
9. Of your current claims inventory, what is the number of claims and percentage of total claims for:
    a. 1 - 7 working days
    b. 8 - 10 working days
    c. 11 - 14 working days
    d. + 15 working days
10. The performance standards for claims processing which includes claims turnaround time, financial (payment) and procedural accuracy are 98%, 99%, and 98% respectively. Can you meet these standards? Are you willing to guarantee your performance with liquidated damages? If so, what do you propose? What is your actual turnaround time for claims? Please fill in the blanks in a., b., and c. below:
    a. 90% of claims processed and sent within __ business days of receipt.
    b. 99% of claims processed and sent within __business days of receipt.
    c. Items a. and b. above are net of claims pended for investigation (e.g., reimbursement requests for repeated tests) by claim adjudicators which Proposer represents do not exceed ____% of claims.
11. What aspects or areas of each claim do you investigate? What claims require a separate supervisory authorization prior to payment?
12. Does your system maintain historical information on submitted expenses and paid claims? How long is this claim history maintained on-line? What procedures do you have in place within the system to avoid paying duplicate bills submitted at separate times? Explain how your system identifies duplicate charges.
13. If a claim has been established in a year for a participant, and subsequent bills come in without a claim form, what is your normal procedure?
14. For Fully Insured proposals, what claim filing deadline do you apply to vision service claims?
15. For Self-Insured proposals, what claim filing deadline would you normally suggest for vision service plans?
16. Under what circumstances may the provider bill the patient directly for any portion of the services provided? How do you ensure that the amounts billed by the provider are consistent with the terms of the Agency's benefits and/or policy related to member out-of-pocket limits (if any are applicable under an Agency's benefits)? How do you ensure that the provider correctly applies any retail discounts offered to members?
17. Do you apply Coordination of Benefits ("COB") to vision care benefit services claims? Describe how COB accumulators function. Are all services subject to COB, or only those above a certain dollar level? Are your rates adjusted to reflect these offsets? Explain your internal procedures for detecting and handling such claims. How does your system calculate claims, apply and maintain COB credits and COB savings? Does your system require an affirmative override action to pay new claims after COB had previously been involved? If a person is covered by two vision care plans, how do you ensure that the vision care service provider correctly applies the terms of both plans to minimize the member out-of-pocket expense?
18. If you intend to subcontract any part of the claims processing function, identify the subcontractor and include the subcontractor's claim processing standards for

production, procedural accuracy and financial accuracy. How will you audit and ensure quality and timeliness of payment?

19. Provide a sample of the monthly claims summary that would accompany your invoices. How are out-of-pocket maximums maintained?
20. Describe your ability to archive and retrieve claim files for up to seven years.
21. Give a precise explanation of your methodology for the calculation of the incurred but not reported ("IBNR") claim reserve, if proposing an insured arrangement.
22. Does your organization offer other claim services such as bill audits, discount negotiation on out of network claims, or special payment arrangements? Are there fees associated with these services? If yes, what are the fees?
23. Provide a sample of the utilization and any other reports that would accompany your invoices.
24. Does your system maintain historical information on submitted expenses and paid claims? How long is this claim history maintained on-line? What procedures do you have in place within the system to avoid paying duplicate bills submitted at separate times? Explain how your system identifies duplicate charges.
25. For Self Insured proposals, please confirm that your monthly billing statements will include the following information:
    a. Group number
    b. Member name
    c. Patient name and relationship to employee
    d. Services
    e. DOB
    f. Provider Number
    g. Provider Procedure
    h. Provider amount
    i. Lab procedure
    j. Non Plan expense
    k. Plan amount
    l. Patient amount
    m. Date(s) of service
    n. Employee ID# (or other unique identifier as requested by the Agency)

Quality Assurance and Review Process

1. To what extent, if any, do you survey members to determine their comprehension of and satisfaction with your program? Do you conduct post-termination member surveys? If yes, how do you follow up on the results of post termination member surveys?
2. Describe your Quality Assurance and review process, detailing the procedures in place for establishing, maintaining, and evaluating the Services.
3. Provide the names and qualifications of the individuals who perform the reviews, and how frequently they occur, indicating the methods and standards used to monitor: a) fraud and abuse; b) appropriateness of care; and c) appropriate calculation of member payments.

4. Has your firm had an Statement of Standards for Attestation Engagement (SSAE) no. 18 (System and Organization Controls (SOC) -1) audit conducted in the last two years? If yes, provide a copy. If no, why not?
5. Confirm that you can provide, upon request and at no additional cost, SOC-1 Type 2 reports that an Agency may require or request in conjunction with its annual audit.
6. Who conducts internal audits and how often are they conducted? Are clients provided information regarding the internal quality control audit reports?
7. Do you develop utilization profiles for your providers? Describe your use of such profiles.
8. How often do you conduct on-site audits of provider locations to determine compliance with your contractual standards and employer plan terms? What is reviewed during an on-site audit?
9. How often do you conduct computer-based data analyses to determine compliance with your contractual standards and employer plan terms? What do you review? Do you share the results of any audit with plan sponsors?
10. How do you monitor provider compliance with continuing education requirements?
11. Do you regularly obtain data regarding professional censure activity pertaining to network providers from available data sources, including state regulatory agencies and professional societies?
12. Describe the most important actions your organization has taken in the last year to improve:
    a. quality of vision services
    b. financial performance
    c. customer/client service
13. Describe your quality assurance and quality management procedures.
14. How do you use encounter data to manage or evaluate vision service provider behavior? Describe incentives/disincentives for provider behavior.
15. During the last three years what programs or process changes or improvements have you initiated as a result of analysis of captured encounter data? Describe the results of any such improvements or changes. Have these programs and processes been focused on cost containment, improved health outcomes, or both? How do you share such data with providers?
16. What specific steps are you taking to improve provider performance in the areas of vision care benefit services management, financial performance, and quality of care?
17. Describe your data analytics capabilities and how they will be used to help the agencies.

Systems Support

1. Describe eligibility processing in detail. Provide sample screens from your eligibility system.
2. Provide a system flow diagram of how your system would be updated upon receipt of an eligibility file. Specify the time frames required to incorporate an Agency's data.
3. List key operational software and identify if the software is purchased, leased or was developed by your organization. Further, describe the operational function the software supports.

4. How does your systems staff interact with your eligibility and customer service staffs? For example, if eligibility files have been received but not yet processed, how are service inquiries for newly eligible (but not processed) enrollees responded to?
5. How long has your claims system been operational? Within what time frames from receipt of data (both initial and ongoing) would eligibility data be loaded into your database? Describe both your system's software and hardware.
6. Provide a detailed history of significant systems and methodology changes and enhancements over the last three years (or since system implementation if less than three years. Do you have plans to significantly alter or enhance your claims administration capabilities? If so, describe.
7. During the last two years, have you experienced an episode of downtime which lasted more than twenty- four consecutive hours?
8. Describe your disaster recovery program, and the procedures followed when your system fails. Is any portion of the current day's input lost if there is a power failure or system failure affecting workstations but not the central system? What historical or current data would be lost due to a power failure or other system failure affecting the central system? How quickly can the backup system be put in place? How would lost files be recreated? Describe the backups: i) If backups are to media, to what media (tape, RAID storage, etc.) are backups written? State whether backups to media are taken to a secure off-site storage location and if so how often? ii) If backups are electronically transmitted to an enterprise class backup service, describe. Each time data is written to storage media (drives), is all data simultaneously written to two or more drives to provide redundancy such that if one drive fails there is a mirrored image stored on another drive?
9. Describe your computer security system.
10. What restrictions are there to computer access? Are passwords stored in an encrypted form? Are they changed on a regular basis? Where is the central system located?
11. What reports are used to reconcile eligibility changes? Who prepares the reports? How are they used in eligibility processing?
12. During the past twenty-four months, have you experienced any data breaches or had to provide notice to members of privacy violations? If yes, please explain.
13. Please provide a copy of your notice to members about your privacy practices.
14. Do you allow claim processors to work from home?
15. Please confirm that you can terminate coverage upon passing of a term date one time only.

Reporting Requirements, Record Keeping Practices, and Audit Practices

1. Describe the record keeping system and the process by which you manage record keeping services at the customer (Agency) level and at the participant level.
2. Provide samples of standard reports that you use in the administration of the program. For example, edit reports used to process a client eligibility file, membership reports, and client reporting for financial and vision care utilization purposes. Indicate whether you have the capacity to generate the following reports. Include a sample report package for a specified period.

a. R&C savings, which lists number of charges received, number of charges reduced, percentage of total, total charges received, and amount saved.
b. Claims distribution, which lists the number, percent of total, average charge, and average paid.
c. Benefits summary, which lists charges, ineligible amounts, basic deductibles (if applicable) co- insurance, COB credits, and amounts paid.
d. Audit savings, which separately lists charges and savings from bill review and specialist fee review due to audit findings. Be specific as to how savings were achieved.

3. What changes have you made in administrative systems within the last three years? How did participants, employers and providers benefit from the changes?
4. Describe:
    a. All internal and external audit processes conducted by your organization to continuously maintain the integrity of the Plan.
    b. Who conducts the internal audits?
    c. How often are internal audits conducted?
    d. How frequently are clients provided with internal quality control audit reports?
5. How do you handle any errors made in the administration of the program? How are errors detected? Provide examples of administrative errors that have been made and describe how the errors were corrected. When are errors reported to the client?
6. Confirm your ability to provide monthly reports that include, but are not limited to the following data:
    a. Services received by each employee or dependent;
    b. Name, and date of birth of person served, as well as unique identifier requested by the Agency such as an employee ID or dependent ID;
    c. Eligibility status of person served (i.e. employee, spouse or dependent;
    d. Date(s) of service;
    e. Name of provider;
    f. Co-payment revenue collected by providers from enrollees; and
    g. Cost of service provided to member.
7. What are the standard utilization activity and management reports that would be produced or otherwise made available at no additional cost? If you offer a client facing reporting tool, how many persons will be allowed access to the reporting suite at no cost to the Agency?
8. Can an Agency design its own reports? Is there an additional charge for these reports? Is there an additional charge for a portal, for special software, or for any other method you have available that allows the employer to access and run its own reports?
9. How are savings on the reports calculated? If there are additional charges, how are the fees calculated and limited?
10. State the number of genders your information management system can accommodate in addition to male and female. If zero, describe your plans, if any, for adding this function.
11. Please delineate any fees associated with a portal or any other method you have available that allows the employer to access and run its own reports.

Qualitative Questions

1. If you are selected to offer services to Agency employees and their dependents beginning January 1, 2025, how will you ensure that they:
    a. Understand their benefits
    b. Take an ownership interest in their vision health?
    c. Come to value the services you (the selected vision care benefits services provider) offer with respect to the quality of services your network providers offer and the value you create for them and their family members?
2. If an employee wished to “opt-up” to a more generous package of vision care benefits than the employer provided, would you recommend that the Agency allow the employee to do so on a voluntary basis? What would be the minimum standards for participation? If your answer is yes, provide a sample plan description of the higher valued vision care program, minimum participation standards, and proposed rates.
3. Would you offer a voluntary benefit for retirees (100% retiree paid)? If so, what would be minimum participation requirements and the terms of such benefit?
4. Many employees and their dependents will perceive that a change in insurance carrier or administrator will have no effect on them e.g. same provider, same benefit terms, etc. and may not perceive any substantive difference. From your perspective, is this a desirable conclusion for them to reach? Is it a reasonable conclusion? State whether employees perceive differences in the following areas from an existing vendor:
    a. Web-applications
    b. Wellness efforts
    c. Quality or quantity of plan communications to members
    d. Value-added services for life management
5. Many of the same providers are in multiple networks. What is different about your efforts in the following areas that would be apparent to the providers?
    a. Data integration.
    b. Plan provider communications
    c. Plan and patient communications
    d. Provider and patient communications
    e. Compensation arrangements
    f. Chronic disease management
    g. Account transition (from carrier X to carrier Y)
6. Provide examples of a successful transition of a small, medium and large sized case from another vendor. A successful transition would include at a minimum:
    a. No disruptions in care or payment for services provided prior to the transition
    b. Improved health status of participants or maintenance of status if improvement is not possible
    c. Increased employee/dependent satisfaction with their vision benefits
    d. Trend reduction or suppression
    e. For purposes of this answer, provide quantitative and qualitative assessments of the key components of a successful transition. Be specific as to what time frames are applicable for a given dimension of success.
7. Do you believe that network size or composition has an effect on the cost of care? Why or why not? Can you quantify your opinion?

HIPAA Compliance

1. Describe the process used by your company to comply with HIPAA EDI, Privacy, and Security requirements. Have you received external or independent certification regarding your HIPAA compliance?
2. Who is the key individual in your organization responsible for compliance with the HIPAA Administrative Simplification provisions? Please identify that individual by name and title.
3. Describe your HIPAA EDI compliance solution relative to providing eligibility data to vendors.
4. Is your staff trained on all Privacy and Security requirements? Describe your training program and enforcement policy.
5. Does your system produce sufficient audit trails to satisfy the HIPAA Privacy and Security regulations?
6. How is security set up in the system? What are the different levels of security?
7. Is your system database encrypted?
8. Are system data backups encrypted?
9. Are all electronic transmissions of PHI, including eligibility files, authorizations, reports, etc., encrypted or sent via secure means? Which encryption methods do you support for e-mails and file transmissions? Please describe.
10. What are your procedures for data destruction prior to hardware and media disposal?
11. Which EDI Transactions sets have you implemented and for those remaining, what is the target implementation date? If you plan to outsource to outside entity, who will be that business partner?
12. Have you had a HIPAA violation in the past three years? If yes, please describe.

SECTION V: COST PROPOSAL

For the electronic version of your cost proposal, use the Microsoft Excel spreadsheet that is provided with this RFP. An additional tab in the Excel spreadsheet, or Microsoft Word, can be used for narrative responses if such are necessary or you believe that additional clarifications to your rate proposal are needed.

Full and complete cost proposals must be submitted. The cost proposal should be clear and unambiguous to allow the Agencies to correctly identify the costs associated with doing business with the Proposer. State the rates and limits for providing Vision Care Benefit Services coverage to the Agencies.

You must offer a E cost proposal for each Agency's current plan and may offer a proposal for any additional benefit offerings that you believe would increase the value of the program to members and the Agency.

If you are offering any discounts on materials including contact lenses, or on professional services (e.g. Lasix or similar services), specify the base price on which the applicable discount would be applied.

If you are offering lens options, provide a description of the specific value of such options which is sufficient to allow a member to understand the incremental value of each type as compared to the other.

If you are offering any insurance related to vision materials (e.g. damage warranty extension, accidental destruction of lenses or frames), provide a sample coverage explanation. Also distinguish the additional warranty provided through the member's purchase of insurance as compared to the normal warranty offered on materials.

Vision Rate Quotations

A. If any rate quote includes fixed prices for additional services, provide the list of additional services as requested in the cost proposal spreadsheet, with the cost of the additional service to the participant and the Agency. For what period of time can you guarantee the additional service price list?
B. Rate quotes may be offered on a per employee per month basis, on a single/couple/family basis, on a single/employee+1/family basis, or on a utilizing member basis. Any utilizing member quote must provide detail that would allow the Agencies to "cross-walk" to a per employee per month basis.

SECTION VI: SUBMITTAL REQUIREMENTS

General. After registering, proposers will receive access to upload documents to the Lead Agency's SharePoint Site. Proposers will also receive Word or Excel (as appropriate) electronic copies of the Scope, Interrogatives, Cost Proposal template, census and claim data, etc. Proposers shall submit responses by the deadline, in accordance with the Submittal Requirements below, and in accordance with the instructions in this RFP (for example, instructions in the Cost Proposal template, in the Scope section above, etc.)

The Agencies have provided plan design information as well as operational and financial data regarding their vision care service programs. This information is found in the Agency Exhibits published as part of this RFP, and in the data files provided to potential proposers who register. Consider this information when responding to the Scope, the Interrogatives, the Cost Proposal and all other aspects of your response to this RFP.

Submitting Responses – Physical and Electronic. Both physical and electronic submissions are required. One electronic response is required; one physical response is required.

Electronic. Electronic Proposals shall be submitted via the Lead Agency's SharePoint site.

- Electronic responses shall be complete except that the Proposer's financial statements published online may be provided by linking to the online financial statements.
- Electronic submissions may be compressed into a standard Zip file format. Do not compress your submission into RAR or other formats. Do not use compression technology that cannot be extracted using Zip software included with Windows.
- Do not encrypt or password protect your responses.

Physical. Physical proposals shall be submitted in sealed boxes to Chicago Benefits Office, 2 N. LaSalle Street, Chicago IL 60602, Room 1240. Delivery personnel should allow time to clear through the security desk and should be prepared to show proper identification. In case of problems accessing Room 1240, call at the Lead Agency at 312-744-6561.

The outside of the boxes must clearly indicate the name of the RFP (i.e. "Request for Proposals for Vision Care Benefits Services June 2024 For the City of Chicago, the Chicago Park District, and City Colleges of Chicago") the specification number of the RFP (i.e. "Spec. #CBO 2024-01"), the time and dates specified for receipt (see "SECTION I: RFP TIMELINE") as well as the name and address of the Proposer.

Where proposals are sent by mail or other courier, the Proposer shall be responsible for timely delivery. If the delivery is delayed beyond the date and time specified for proposal receipt, the proposal may not be considered. Physical responses shall be complete except that the Proposer's financial statements published online may be provided by linking to the online financial statements. Delivery of the physical proposals should include delivery of the sample frames specified in Section IV, Interrogatives, above.

Scope and Interrogatives. Reproduce each Scope requirement and confirm you propose to meet that requirement. Exceptions to your proposal to meet the Scope requirements shall be specific and shall be provided in the manner specified in the Scope. Reproduce each Interrogative and address it.

Agency Exhibits. Read the Agency Exhibits and comply with any Agency specific requirements.

Sample Professional Services Agreement. For each Agency's Agency Exhibit which includes a sample Professional Services Agreement, if you object to any provision as unacceptable, propose changes and redline those changes. Failure to do so shall be considered acceptance of the sample language. Other forms of response are unacceptable (e.g. submittal of an alternative standard form contract) and may be grounds for disqualification.

Providers. The Agencies have provided information regarding the vision care service providers used by their members in an Excel spreadsheet. You will find the spreadsheet within the set of the data files provided to potential proposers who register; the spreadsheet is one combined provider file for all three agencies. Please use this one combined provider file to answer the following: Please determine if these providers are included in your vision services network and update the spreadsheet as directed. Please also list any other providers in the metropolitan Chicago area that are in your network but are not included in the spreadsheet provided.

Geo-Access. The Agencies have provided information regarding residential addresses of members, by census zip code. You will find the census zip code files within the set of data files provided to potential proposers who register. One zip code file is provided for each agency. Please provide 6 separate reports, two for each agency, as you respond to the following: Using the census zip code data provided on the data file, provide a Geo-Access analysis of your vision care network, using a two-mile radius. Provide a separate analysis using a five-mile radius.

Cost Proposal. Provide the Cost Proposal as required in the immediately preceding section.

Instructions on "SECTION I: RFP TIMELINE". Proposals shall be submitted in accordance with the instructions in "SECTION I: RFP TIMELINE" (e.g. by the submittal deadline, in the form and manner and to the delivery address specified).

Proposer. The entity proposing to provide the services shall be the entity which responds to the RFP and which signs the Proposer's Execution Page below and, if selected, which ultimately signs a contract with the Agency.

Proposer's Execution Page. Proposals shall be accompanied by a Proposer's execution page, reproduced on the Proposer's letterhead, referring to Specification #CBO-2024-01, and signed by an authorized officer of Proposer, as follows:

"_____________________ [insert name of Proposer] (A) represents and warrants that all responses to all interrogatives are true and correct, (B) proposes to perform each and every

element of the Scope unless specifically excepted in its response, (C) hereby commits that, if selected will faithfully comply with all elements of its proposal unless otherwise accepted by the Agencies or with respect to an Agency by that Agency and (D) authorizes release of information under the Freedom of Information Act to the extend not redacted in accordance with the submittal requirements of the RFP."

Redacted Copies for FOIA. All material submitted may be made available in accordance with the Freedom of Information Act (FOIA) irrespective of whether the Proposal may contain trade secrets or other proprietary information. However, if the Respondent considers portions of its proposal to be confidential and not subject to FOIA, then such determination must be managed as follows:

- In addition to the proposal, provide two complete duplicate copies redacted for FOIA purposes, one in hard copy with the physical proposal and the other in electronic format, uploaded to the SharePoint site. These complete redacted copies shall be completely separate, as described below.
- The redacted content shall be blacked-out. Failure to black out redacted content (for example by merely claiming "the following paragraph is confidential" or "column three (3) is confidential") will result in content not being treated as confidential and being released under FOIA.
- Only content that is a trade secret or proprietary shall be redacted.
- Provide a key describing what content was redacted and why the redacted content was redacted, citing the specific FOIA reference which justifies the redaction being made. Cite to the Illinois Freedom of Information Act 5 ILCS 140.
- *Complete Separation*. Both the redacted electronic copy and the redacted physical copy shall be complete copies of the entire RFP response with redactions blacked out. The complete physical redacted hard copy shall be in a separate 3-ring binder or binders. The complete electronic redacted copy shall be in a separate subfolder within the electronic submission. Mingling redacted and unredacted material shall result in the Agency treating the entire submission as unredacted public information.
- Overly broad or wholesale redacting of content that is not a trade secret or other proprietary data shall constitute failure to follow this procedure, and may result in content not being treated as confidential.
- Redaction requirements apply to the initial RFP response as well as any and all communications responsive to or in connection with this RFP including but not limited to updates, addenda, handouts, emails, offers, etc.
- Failure to follow this procedure will lead to the release of responses under a FOIA request, and because responses will not be treated as confidential may lead to other release of responses.

False Statements. Be advised, any person who knowingly makes a false statement of material fact to the city or any Agency in violation of any statute, ordinance, or regulation, or who knowingly falsifies any statement of material fact made in connection with an application, report, affidavit, oath, or attestation, including a statement of material fact made in connection with a bid, proposal, contract or economic disclosure statement, or affidavit, is liable to the City for a civil penalty of not less than $500.00 and not more than $1,000.00, plus up to three times

the amount of damages which the City sustains because of the person's violation of this section. A person who violates this section shall also be liable for the City's litigation and collection costs and attorney's fees. The penalties imposed by this section shall be in addition to any other penalty provided for in the municipal code. (Added Coun. J. 12-15-04, p. 39915, § 1). Any person who aids, abets, incites, compels or coerces the doing of any act prohibited by this chapter shall be liable to the City for the same penalties for the violation. (Added Coun. J. 12-15-04, p. 39915, § 1). In addition to any other means authorized by law, the corporation counsel may enforce this chapter by instituting an action with the Department of Administrative Hearings. (Added Coun. J. 12-15-04, p. 39915, § 1)

SECTION VII: PROPOSAL EVALUATION AND CONTRACT AWARD PROCEDURES

A. Evaluation Procedures

All proposals accepted by the Agencies will be reviewed to determine whether they are responsive or non-responsive to the requirements of the RFP. Proposals that are determined by the Agencies to be non-responsive may be rejected. The Agencies' Evaluation Committee will evaluate and rate all remaining proposals based on the Evaluation Criteria prescribed below. The proposals will be ranked in order of highest to lowest score, taking into account the evaluation criteria listed below, and the Evaluation Committee will establish a short-list. The Agencies will request that the short-list of Respondents participate in in-person presentations and/or demonstrations as the Agencies deem applicable and appropriate. The Agencies reserve the right to first request clarifications and/or Best and Final Offers (BAFOs) at any time, to do rescoring(s) before establishing the final short list, and to do rescoring(s) thereafter prior to making a selection.

B. Evaluation Criteria:

General. The Agencies may consider any factors the Agencies deem necessary or desirable to determine the best overall value and most advantageous selection, based upon, and including but not limited to, the following criteria:

- Submittal Requirements. Compliance with the Submittal Requirements.
- Minimum Requirements. Whether Respondent meets requirements 1-9 of Section III above.
- Qualifications. Proposer's professional qualifications, specialized experience and local availability of key personnel committed to perform vision care services. Proposers should demonstrate having clients similar in size to the Agencies, or larger. Proposers should demonstrate relevant experience, both quantitatively and qualitatively.
- Flexible and Responsive. Ability to clearly demonstrate strength and experience, as Contractor, in its ability to be very responsive to changes in the vision care services Plan offerings required as the result of changes in collectively bargained benefits and/or arbitration awards and requests of the Agencies.
- Capability and Execution. Proposers are evaluated on demonstrated level of organizational capability, demonstrated quality of approach and quality of sample frames.
- Limited Scope of Service Exceptions. Respondent's proposals to perform, or exceptions to, Scopes of Services. The degree to which the Proposer accepts the Scope of Service requirements as presented by the Agencies, and other Agency Exhibit requirements.
- Performance Guarantees. Offer competitive performance guarantees to the Agencies related to implementation and on-going vision care services.
- Terms and Conditions. No exceptions to sample Terms and Conditions to be included in Professional Services Agreement to the extent included in Agency exhibits, or if exceptions are noted, the acceptability to the Agencies of those noted exceptions. Willingness to sign each Agency's Business Associate Agreement or the Business Associate section of the Agency's Professional Services Agreement. Willingness to

adhere to the data security requirements disclosed in the Agency exhibits (e.g. the City of Chicago's Information Security and Technology Policies)

- MBE/WBE Participation. The level, relevancy, and quality of participation with Agency MBE/WBE requirements or policies.
- Financial Stability. The financial condition of Proposer, including but not limited to factors indicating financial stability to ensure performance over the duration of the contract.
- Legal Concerns. Disclosed or undisclosed legal concerns regarding Proposer or any of its divisions, subsidiaries, affiliate or its parent.
- Conflicts of Interest. Anything that may indicate any conflicts (or potential conflicts) of interest which might compromise Proposer's ability to satisfactorily perform the proposed vision care services or which might undermine the integrity of the competitive procurement process.
- Quality of Response. Proposers will also be evaluated on the quality of the response with regard to, inter alia, the following:
  - "Will discuss" and "will consider" are not appropriate answers.
  - A reference to the current contractual terms by any incumbent is not an appropriate answer.
- Cost of Service. Proposer's cost proposal, overall cost structure and approaches to controlling the cost of covered benefits while providing appropriate access for members. Rate quotations must include a minimum rate guarantee period of 36 months.
- Other. Any other factors the Agencies deem necessary or desirable to determine the best overall value and most advantageous selection.

C. Basis for Contract Award:

A contract may be awarded to the responsible proposer whose proposal is determined to be the most advantageous to the Agencies, taking into consideration the price and such other factors or criteria which are set forth in this RFP.

Contract award shall be contingent upon the timely completion of contract negotiations between the Agency and the selected Proposer. An Agency unable to successfully negotiate a contract with the selected Proposer may decide to terminate further negotiations with such Proposer and elect to commence negotiations with the next most qualified Proposer.

SECTION VIII: AGENCY EXHIBITS

(See separate Agency Exhibits document)