State Term Contract 80111502-19-1
For
Benefits Consulting, Actuarial and Claims Auditing Services

This Contract is between the State of Florida, Department of Management Services (Department), an agency of the State of Florida and Mercer Health & Benefits LLC (Contractor), with its principal place of business at 333 West 34th Street, New York, NY 10036, collectively referred to herein as the "Parties."

The Contractor was awarded to provide the following Service Category(ies): Service Category 1 – Benefits Consulting, Service Category 2 – Actuarial, and Service Category 3 – Claims Auditing.

Accordingly, the Parties agree as follows:

I. Initial Contract Term.

The Initial Contract Term shall be for five years. The Initial Contract Term shall begin on December 17, 2019. The Contract shall expire on December 16, 2024, unless terminated earlier in accordance with the incorporated Special Contract Conditions.

II. Renewal Term.

Upon mutual written agreement, the Parties may renew this Contract, in whole or in part, for a Renewal Term not to exceed the Initial Contract Term, pursuant to the incorporated Special Contract Conditions.

III. Contract.

As used in this document, "Contract" (whether or not capitalized) shall, unless the context requires otherwise, include this document and all incorporated Exhibits, which set forth the entire understanding of the Parties and supersedes all prior agreements. All modifications to this Contract must be in writing and signed by all Parties.

All Exhibits listed below are incorporated in their entirety into, and form part of, this Contract. The Contract Exhibits shall have priority in the order listed:

a) Special Contract Conditions, Exhibit A
b) Addenda to Solicitation (in reverse order of issuance), Exhibit B
c) RFP and RFP attachments (includes Scope of Work), Exhibit C
d) Contractor's Cost Proposal, for each Service Category(ies), Exhibit D
e) Contractor's Technical Proposal for each Service Category(ies), Exhibit E

IV. Contract Management.

Department's Contract Manager:
Christia Nunnery
Division of State Purchasing
Florida Department of Management Services
4050 Esplanade Way, Suite 360.8X
Tallahassee, Florida 32399-0950
Telephone: (850) 488-8367
Email: Christia.Nunnery@dms.myflorida.com

Contractor's Contract Manager:
Kenneth C. Vieira
Mercer Health & Benefits LLC
1166 Avenue of the Americas
New York, New York 10036
Telephone: (404) 442-3457
Email: keith.hanson@mercer.com

IN WITNESS THEREOF, the Parties hereto have caused this Contract, which includes the incorporated Exhibits, to be executed by their undersigned officials as duly authorized. This Contract is not valid and binding until signed and dated by the Parties.

MERCER HEALTH & BENEFITS LLC	**STATE OF FLORIDA, DEPARTMENT OF MANAGEMENT SERVICES**
_____	_____
	Rosalyn Ingram, Chief Procurement Officer and Director of State Purchasing
_____	_____
Date:	**Date:**

IV. Contract Management.

Department's Contract Manager:
Christia Nunnery
Division of State Purchasing
Florida Department of Management Services
4050 Esplanade Way, Suite 360.8X
Tallahassee, Florida 32399-0950
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MERCER HEALTH & BENEFITS LLC

Keith Hanson

12/18/19

Date:

STATE OF FLORIDA, DEPARTMENT OF MANAGEMENT SERVICES

Rosalyn Ingram,
Chief Procurement Officer and Director of State Purchasing

12/19/19

Date:

EXHIBIT A

SPECIAL CONTRACT CONDITIONS
JULY 1, 2019 VERSION

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In accordance with Rule 60A-1.002(7), F.A.C., Form PUR 1000 is included herein by reference but is superseded in its entirety by these Special Contract Conditions.

SECTION 1. DEFINITION.

The following definition applies in addition to the definitions in Chapter 287, Florida Statutes (F.S.), and Rule Chapter 60A-1, Florida Administrative Code (F.A.C.):

1.1 Customer.
The agency or eligible user that purchases commodities or contractual services pursuant to the Contract.

SECTION 2. CONTRACT TERM AND TERMINATION.

2.1 Initial Term.
The initial term will begin on the date set forth in the Contract documents or on the date the Contract is signed by all Parties, whichever is later.

2.2 Renewal.
Upon written agreement, the Department and the Contractor may renew the Contract in whole or in part only as set forth in the Contract documents, and in accordance with section 287.057(13), F.S.

2.3 Suspension of Work and Termination.

2.3.1 Suspension of Work.
The Department may, at its sole discretion, suspend any or all activities under the Contract, at any time, when it is in the best interest of the State of Florida to do so. The Customer may suspend a resulting contract or purchase order, at any time, when in the best interest of the Customer to do so. The Department or Customer will provide the Contractor written notice outlining the particulars of the suspension. After receiving a suspension notice, the Contractor must comply with the notice and will cease the performance of the Contract or purchase order. Suspension of work will not entitle the Contractor to any additional compensation. The Contractor will not resume performance of the Contract or purchase order until so authorized by the Department.

2.3.2 Termination for Convenience.
The Contract may be terminated by the Department in whole or in part at any time, in the best interest of the State of Florida. If the Contract is terminated before performance is completed, the Contractor will be paid only for that work satisfactorily performed for which costs can be substantiated. Such payment, however, may not exceed an amount which is the same percentage of the Contract price as the amount of work satisfactorily performed. All work in progress will become the property of the Customer and will be turned over promptly by the Contractor.

2.3.3 Termination for Cause.
If the performance of the Contractor is not in compliance with the Contract requirements or the Contractor has defaulted, the Department may:

(a) immediately terminate the Contract;
(b) notify the Contractor of the noncompliance or default, require correction, and specify the date by which the correction must be completed before the Contract is terminated; or
(c) take other action deemed appropriate by the Department.

SECTION 3. PAYMENT AND FEES.

3.1 Pricing.
The Contractor will not exceed the pricing set forth in the Contract documents.

3.2 Price Decreases.
The following price decrease terms will apply to the Contract:

3.2.1 Quantity Discounts. Contractor may offer additional discounts for one-time delivery of large single orders;

3.2.2 Preferred Pricing. The Contractor guarantees that the pricing indicated in this Contract is a maximum price. Additionally, Contractor's pricing will not exceed the pricing offered under comparable contracts. Comparable contracts are those that are similar in size, scope, and terms. In compliance with section 216.0113, F.S., Contractor must annually submit an affidavit from the Contractor's authorized representative attesting that the Contract complies with this clause.

3.2.3 Sales Promotions. In addition to decreasing prices for the balance of the Contract term due to a change in market conditions, the Contractor may conduct sales promotions involving price reductions for a specified lesser period. The Contractor must submit documentation identifying the proposed: (1) starting and ending dates of the promotion, (2) commodities or contractual services involved, and (3) promotional prices compared to then-authorized prices.

3.3 Payment Invoicing.
The Contractor will be paid upon submission of invoices to the Customer after delivery and acceptance of commodities or contractual services is confirmed by the Customer. Invoices must contain sufficient detail for an audit and contain the Contract Number and the Contractor's Federal Employer Identification Number.

3.4 Purchase Order.
A Customer may use purchase orders to buy commodities or contractual services pursuant to the Contract and, if applicable, the Contractor must provide commodities or contractual services pursuant to purchase orders. Purchase orders issued pursuant to the Contract must be received by the Contractor no later than the close of business on the last day of the Contract's term. The Contractor is required to accept timely purchase orders specifying delivery schedules that extend beyond the Contract term even when such extended delivery will occur after expiration of the Contract. Purchase orders shall be valid through their specified term and performance by the Contractor, and all terms and conditions of the Contract shall survive the termination or expiration of the Contract and apply to the Contractor's performance. The duration of purchase orders for recurring deliverables shall not exceed the expiration of the Contract by more than twelve months. Any purchase order terms and conditions conflicting with these Special Contract Conditions shall not become a part of the Contract.

3.5 Travel.
Travel expenses are not reimbursable unless specifically authorized by the Customer in writing and may be reimbursed only in accordance with section 112.061, F.S.

3.6 Annual Appropriation.
Pursuant to section 287.0582, F.S., if the Contract binds the State of Florida or an agency for the purchase of services or tangible personal property for a period in excess of one fiscal year, the State of Florida's performance and obligation to pay under the Contract is contingent upon an annual appropriation by the Legislature.

3.7 Transaction Fees.
The State of Florida, through the Department of Management Services, has instituted MyFloridaMarketPlace, a statewide eProcurement system pursuant to section 287.057(22), F.S. All payments issued by Customers to registered Vendors for purchases of commodities or contractual services will be assessed Transaction Fees as prescribed by rule 60A-1.031, F.A.C., or as may otherwise be established by law. Vendors must pay the Transaction Fees and agree to automatic deduction of the Transaction Fees when automatic deduction becomes available. Vendors will submit any monthly reports required pursuant to the rule. All such reports and payments will be subject to audit. Failure to comply with the payment of the Transaction Fees or reporting of transactions will constitute grounds for declaring the Vendor in default and subject the Vendor to exclusion from business with the State of Florida.

3.8 Taxes.
Taxes, customs, and tariffs on commodities or contractual services purchased under the Contract will not be assessed against the Customer or Department unless authorized by Florida law.

3.9 Return of Funds.
Contractor will return any overpayments due to unearned funds or funds disallowed pursuant to the terms of the Contract that were disbursed to the Contractor. The Contractor must return any overpayment within forty (40) calendar days after either discovery by the Contractor, its independent auditor, or notification by the Department or Customer of the overpayment.

SECTION 4. CONTRACT MANAGEMENT.

4.1 Composition and Priority.
The Contractor agrees to provide commodities or contractual services to the Customer as specified in the Contract. Additionally, the terms of the Contract supersede the terms of all prior agreements between the Parties on this subject matter.

4.2 Notices.
All notices required under the Contract must be delivered to the designated Contract Manager in a manner identified by the Department.

4.3 Department's Contract Manager.
The Department's Contract Manager, who is primarily responsible for the Department's oversight of the Contract, will be identified in a separate writing to the Contractor upon Contract signing in the following format:

Department's Contract Manager Name

Department's Name
Department's Physical Address
Department's Telephone #
Department's Email Address

If the Department changes the Contract Manager, the Department will notify the Contractor. Such a change does not require an amendment to the Contract.

4.4 Contractor's Contract Manager.
The Contractor's Contract Manager, who is primarily responsible for the Contractor's oversight of the Contract performance, will be identified in a separate writing to the Department upon Contract signing in the following format:

Contractor's Contract Manager Name
Contractor's Name
Contractor's Physical Address
Contractor's Telephone #
Contractor's Email Address

If the Contractor changes its Contract Manager, the Contractor will notify the Department. Such a change does not require an amendment to the Contract.

4.5 Diversity.

4.5.1 Office of Supplier Diversity.
The State of Florida supports its diverse business community by creating opportunities for woman-, veteran-, and minority-owned small business enterprises to participate in procurements and contracts. The Department encourages supplier diversity through certification of woman-, veteran-, and minority-owned small business enterprises and provides advocacy, outreach, and networking through regional business events. For additional information, please contact the Office of Supplier Diversity (OSD) at osdinfo@dms.myflorida.com.

4.5.2 Diversity Reporting.
Upon request, the Contractor will report to the Department its spend with business enterprises certified by the OSD. These reports must include the time period covered, the name and Federal Employer Identification Number of each business enterprise utilized during the period, commodities and contractual services provided by the business enterprise, and the amount paid to the business enterprise on behalf of each agency purchasing under the Contract.

4.6 RESPECT.
Subject to the agency determination provided for in section 413.036, F.S., the following statement applies:

IT IS EXPRESSLY UNDERSTOOD AND AGREED THAT ANY ARTICLES THAT ARE THE SUBJECT OF, OR REQUIRED TO CARRY OUT, THIS CONTRACT SHALL BE PURCHASED FROM A NONPROFIT AGENCY FOR THE BLIND OR FOR THE SEVERELY HANDICAPPED THAT IS QUALIFIED PURSUANT TO CHAPTER 413, FLORIDA STATUTES, IN THE SAME MANNER AND UNDER THE SAME PROCEDURES SET FORTH IN SECTION 413.036(1) AND (2), FLORIDA STATUTES;

AND FOR PURPOSES OF THIS CONTRACT THE PERSON, FIRM, OR OTHER BUSINESS ENTITY CARRYING OUT THE PROVISIONS OF THIS CONTRACT SHALL BE DEEMED TO BE SUBSTITUTED FOR THE STATE AGENCY INSOFAR AS DEALINGS WITH SUCH QUALIFIED NONPROFIT AGENCY ARE CONCERNED.

Additional information about RESPECT and the commodities or contractual services it offers is available at https://www.respectofflorida.org.

4.7 PRIDE.
Subject to the agency determination provided for in sections 287.042(1) and 946.515, F.S., the following statement applies:

IT IS EXPRESSLY UNDERSTOOD AND AGREED THAT ANY ARTICLES WHICH ARE THE SUBJECT OF, OR REQUIRED TO CARRY OUT, THIS CONTRACT SHALL BE PURCHASED FROM THE CORPORATION IDENTIFIED UNDER CHAPTER 946, F.S., IN THE SAME MANNER AND UNDER THE SAME PROCEDURES SET FORTH IN SECTION 946.515(2) AND (4), F.S.; AND FOR PURPOSES OF THIS CONTRACT THE PERSON, FIRM, OR OTHER BUSINESS ENTITY CARRYING OUT THE PROVISIONS OF THIS CONTRACT SHALL BE DEEMED TO BE SUBSTITUTED FOR THIS AGENCY INSOFAR AS DEALINGS WITH SUCH CORPORATION ARE CONCERNED.

Additional information about PRIDE and the commodities or contractual services it offers is available at https://www.pride-enterprises.org.

SECTION 5. COMPLIANCE WITH LAWS.

5.1 Conduct of Business.
The Contractor must comply with all laws, rules, codes, ordinances, and licensing requirements that are applicable to the conduct of its business, including those of federal, state, and local agencies having jurisdiction and authority. For example, the Contractor must comply with section 274A of the Immigration and Nationality Act, the Americans with Disabilities Act, Health Insurance Portability and Accountability Act, if applicable, and all prohibitions against discrimination on the basis of race, religion, sex, creed, national origin, handicap, marital status, or veteran's status. The provisions of subparagraphs 287.058(1)(a)-(c), and (g), F.S., are hereby incorporated by reference.

5.2 Dispute Resolution, Governing Law, and Venue.
Any dispute concerning performance of the Contract shall be decided by the Department's designated Contract Manager, who will reduce the decision to writing and serve a copy on the Contractor. The decision of the Contract Manager shall be final and conclusive. Exhaustion of this administrative remedy is an absolute condition precedent to the Contractor's ability to pursue legal action related to the Contract or any other form of dispute resolution. The laws of the State of Florida govern the Contract. The Parties submit to the jurisdiction of the courts of the State of Florida exclusively for any legal action related to the Contract. Further, the Contractor hereby waives all privileges and rights relating to venue it may have under Chapter 47, F.S., and all such venue privileges and rights it may have under any other statute, rule, or case law, including, but not limited to, those based on convenience. The Contractor hereby submits to venue in the county chosen by the Department.

5.3 Department of State Registration.

Consistent with Title XXXVI, F.S., the Contractor and any subcontractors that assert status, other than a sole proprietor, must provide the Department with conclusive evidence of a certificate of status, not subject to qualification, if a Florida business entity, or of a certificate of authorization if a foreign business entity.

5.4 Suspended, Convicted, and Discriminatory Vendor Lists.
In accordance with sections 287.042, 287.133, and 287.134, F.S., an entity or affiliate who is on the Suspended Vendor List, Convicted Vendor List, or Discriminatory Vendor List may not perform work as a contractor, supplier, subcontractor, or consultant under the Contract. The Contractor must notify the Department if it or any of its suppliers, subcontractors, or consultants have been placed on the Suspended Vendor List, Convicted Vendor List, or Discriminatory Vendor List during the term of the Contract.

5.5 Scrutinized Companies - Termination by the Department.
The Department may, at its option, terminate the Contract if the Contractor is found to have submitted a false certification as provided under section 287.135(5), F.S., or been placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, or been engaged in business operations in Cuba or Syria, or to have been placed on the Scrutinized Companies that Boycott Israel List or is engaged in a boycott of Israel.

5.6 Cooperation with Inspector General and Records Retention.
Pursuant to section 20.055(5), F.S., the Contractor understands and will comply with its duty to cooperate with the Inspector General in any investigation, audit, inspection, review, or hearing. Upon request of the Inspector General or any other authorized State official, the Contractor must provide any information the Inspector General deems relevant to the Contractor's integrity or responsibility. Such information may include, but will not be limited to, the Contractor's business or financial records, documents, or files of any type or form that refer to or relate to the Contract. The Contractor will retain such records for the longer of five years after the expiration of the Contract, or the period required by the General Records Schedules maintained by the Florida Department of State, at the Department of State’s Records Management website. The Contractor agrees to reimburse the State of Florida for the reasonable costs of investigation incurred by the Inspector General or other authorized State of Florida official for investigations of the Contractor's compliance with the terms of this or any other agreement between the Contractor and the State of Florida which results in the suspension or debarment of the Contractor. Such costs will include but will not be limited to: salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The Contractor agrees to impose the same obligations to cooperate with the Inspector General and retain records on any subcontractors used to provide goods or services under the Contract.

SECTION 6. MISCELLANEOUS.

6.1 Subcontractors.
The Contractor will not subcontract any work under the Contract without prior written consent of the Department. The Contractor is fully responsible for satisfactory completion of all its subcontracted work. The Department supports diversity in its procurements and contracts, and requests that the Contractor offer subcontracting opportunities to certified woman-, veteran-, and minority-owned small businesses. The

Contractor may contact the OSD at osdhelp@dms.myflorida.com for information on certified small business enterprises available for subcontracting opportunities.

6.2 Assignment.
The Contractor will not sell, assign, or transfer any of its rights, duties, or obligations under the Contract without the prior written consent of the Department. However, the Contractor may waive its right to receive payment and assign same upon notice to the Department. In the event of any assignment, the Contractor remains responsible for performance of the Contract, unless such responsibility is expressly waived by the Department. The Department may assign the Contract with prior written notice to the Contractor.

6.3 Independent Contractor.
The Contractor and its employees, agents, representatives, and subcontractors are independent contractors and not employees or agents of the State of Florida and are not entitled to State of Florida benefits. The Department and Customer will not be bound by any acts or conduct of the Contractor or its employees, agents, representatives, or subcontractors. The Contractor agrees to include this provision in all its subcontracts under the Contract.

6.4 Inspection and Acceptance of Commodities.

6.4.1 Risk of Loss.
Matters of inspection and acceptance are addressed in section 215.422, F.S. Until acceptance, risk of loss or damage will remain with the Contractor. The Contractor will be responsible for filing, processing, and collecting all damage claims. To assist the Contractor with damage claims, the Customer will: record any evidence of visible damage on all copies of the delivering carrier's bill of lading; report damages to the carrier and the Contractor; and provide the Contractor with a copy of the carrier's bill of lading and damage inspection report.

6.4.2 Rejected Commodities.
When a Customer rejects a commodity, Contractor will remove the commodity from the premises within ten (10) calendar days after notification of rejection, and the risk of loss will remain with the Contractor. Commodities not removed by the Contractor within ten (10) calendar days will be deemed abandoned by the Contractor, and the Customer will have the right to dispose of such commodities. Contractor will reimburse the Customer for costs and expenses incurred in storing or effecting removal or disposition of rejected commodities.

6.5 Safety Standards.
Performance of the Contract for all commodities or contractual services must comply with requirements of the Occupational Safety and Health Act and other applicable State of Florida and federal requirements.

6.6 Ombudsman.
A Vendor Ombudsman has been established within the Department of Financial Services. The duties of this office are found in section 215.422, F.S., which include disseminating information relative to prompt payment and assisting contractors in receiving their payments in a timely manner from a Customer. The Vendor Ombudsman may be contacted at (850) 413-5516.

6.7 Time is of the Essence.
Time is of the essence regarding every obligation of the Contractor under the Contract. Each obligation is deemed material, and a breach of any such obligation (including a breach resulting from untimely performance) is a material breach.

6.8 Waiver.
The delay or failure by the Department or the Customer to exercise or enforce any rights under the Contract will not constitute waiver of such rights.

6.9 Modification and Severability.
The Contract may only be modified by written agreement between the Department and the Contractor. Should a court determine any provision of the Contract is invalid, the remaining provisions will not be affected, and the rights and obligations of the Parties will be construed and enforced as if the Contract did not contain the provision held invalid.

6.10 Cooperative Purchasing.
Pursuant to their own governing laws, and subject to the agreement of the Contractor, governmental entities that are not Customers may make purchases under the terms and conditions contained herein, if agreed to by Contractor. Such purchases are independent of the Contract between the Department and the Contractor, and the Department is not a party to these transactions. Agencies seeking to make purchases under this Contract are required to follow the requirements of Rule 60A-1.045(5), F.A.C.

SECTION 7. LIABILITY AND INSURANCE.

7.1 Workers' Compensation Insurance.
The Contractor shall maintain workers' compensation insurance as required under the Florida Workers' Compensation Law or the workers' compensation law of another jurisdiction where applicable. The Contractor must require all subcontractors to similarly provide workers' compensation insurance for all of the latter's employees. In the event work is being performed by the Contractor under the Contract and any class of employees performing the work is not protected under Workers' Compensation statutes, the Contractor must provide, and cause each subcontractor to provide, adequate insurance satisfactory to the Department, for the protection of employees not otherwise protected.

7.2 General Liability Insurance.
The Contractor must secure and maintain Commercial General Liability Insurance, including bodily injury, property damage, products, personal and advertising injury, and completed operations. This insurance must provide coverage for all claims that may arise from performance of the Contract or completed operations, whether by the Contractor or anyone directly or indirectly employed by the Contractor. Such insurance must include the State of Florida as an additional insured for the entire length of the resulting contract. The Contractor is responsible for determining the minimum limits of liability necessary to provide reasonable financial protections to the Contractor and the State of Florida under the resulting contract.

7.3 Florida Authorized Insurers.

All insurance shall be with insurers authorized and eligible to transact the applicable line of insurance business in the State of Florida. The Contractor shall provide Certification(s) of Insurance evidencing that all appropriate coverage is in place and showing the Department to be an additional insured.

7.4 Performance Bond.
Unless otherwise prohibited by law, the Department may require the Contractor to furnish, without additional cost to the Department, a performance bond or irrevocable letter of credit or other form of security for the satisfactory performance of work hereunder. The Department shall determine the type and amount of security.

7.5 Indemnification.
To the extent permitted by Florida law, the Contractor agrees to indemnify, defend, and hold the Customer and the State of Florida, its officers, employees, and agents harmless from all fines, claims, assessments, suits, judgments, or damages, including consequential, special, indirect, and punitive damages, including court costs and attorney's fees, arising from or relating to violation or infringement of a trademark, copyright, patent, trade secret, or intellectual property right or out of any acts, actions, breaches, neglect, or omissions of the Contractor, its employees, agents, subcontractors, assignees, or delegates related to the Contract, as well as for any determination arising out of or related to the Contract that the Contractor or Contractor's employees, agents, subcontractors, assignees, or delegates are not independent contractors in relation to the Customer. The Contract does not constitute a waiver of sovereign immunity or consent by the Customer or the State of Florida or its subdivisions to suit by third parties. Without limiting this indemnification, the Customer may provide the Contractor (1) written notice of any action or threatened action, (2) the opportunity to take over and settle or defend any such action at Contractor's sole expense, and (3) assistance in defending the action at Contractor's sole expense.

7.6 Limitation of Liability.
Unless otherwise specifically enumerated in the Contract or in the purchase order, neither the Department nor the Customer shall be liable for special, indirect, punitive, or consequential damages, including lost data or records (unless the Contract or purchase order requires the Contractor to back-up data or records), even if the Department or Customer has been advised that such damages are possible. Neither the Department nor the Customer shall be liable for lost profits, lost revenue, or lost institutional operating savings. The Department or Customer may, in addition to other remedies available to them at law or equity and upon notice to the Contractor, retain such monies from amounts due Contractor as may be necessary to satisfy any claim for damages, penalties, costs, and the like asserted by or against them. The State may set off any liability or other obligation of the Contractor or its affiliates to the State against any payments due the Contractor under any contract with the State.

SECTION 8. PUBLIC RECORDS, TRADE SECRETS, DOCUMENT MANAGEMENT, AND INTELLECTUAL PROPERTY.

8.1 Public Records.

8.1.1 Termination of Contract.

The Department may terminate the Contract for refusal by the Contractor to comply with this section by not allowing access to all public records, as defined in Chapter 119, F. S., made or received by the Contractor in conjunction with the Contract.

8.1.2 Statutory Notice.
Pursuant to section 119.0701(2)(a), F.S., for contracts for services with a contractor acting on behalf of a public agency, as defined in section 119.011(2), F.S., the following applies:

IF THE CONTRACTOR HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE CONTRACTOR'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS CONTRACT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS AT THE TELEPHONE NUMBER, EMAIL ADDRESS, AND MAILING ADDRESS PROVIDED IN THE RESULTING CONTRACT OR PURCHASE ORDER.

Pursuant to section 119.0701(2)(b), F.S., for contracts for services with a contractor acting on behalf of a public agency as defined in section 119.011(2), F.S., the Contractor shall:

(a) Keep and maintain public records required by the public agency to perform the service.
(b) Upon request from the public agency's custodian of public records, provide the public agency with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, F.S., or as otherwise provided by law.
(c) Ensure that public records that are exempt or confidential and exempt from public records disclosure are not disclosed except as authorized by law for the duration of the Contract term and following the completion of the Contract if the Contractor does not transfer the records to the public agency.
(d) Upon completion of the Contract, transfer, at no cost, to the public agency all public records in possession of the Contractor or keep and maintain public records required by the public agency to perform the service. If the Contractor transfers all public records to the public agency upon completion of the Contract, the Contractor shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If the Contractor keeps and maintains public records upon completion of the Contract, the Contractor shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the public agency, upon request from the public agency's custodian of public records, in a format that is compatible with the information technology systems of the public agency.

8.2 Protection of Trade Secrets or Otherwise Confidential Information.

8.2.1 Contractor Designation of Trade Secrets or Otherwise Confidential Information.
If the Contractor considers any portion of materials to be trade secret under section 688.002 or 812.081, F.S., or otherwise confidential under Florida or federal law, the Contractor must clearly designate that portion of the materials as trade secret or otherwise confidential when submitted to the Department. The Contractor will be

responsible for responding to and resolving all claims for access to Contract-related materials it has designated trade secret or otherwise confidential.

8.2.2 Public Records Requests.
If the Department receives a public records request for materials designated by the Contractor as trade secret or otherwise confidential under Florida or federal law, the Contractor will be responsible for taking the appropriate legal action in response to the request. If the Contractor fails to take appropriate and timely action to protect the materials designated as trade secret or otherwise confidential, the Department will provide the materials to the requester.

8.2.3 Indemnification Related to Confidentiality of Materials.
The Contractor will protect, defend, indemnify, and hold harmless the Department for claims, costs, fines, and attorney's fees arising from or relating to its designation of materials as trade secret or otherwise confidential.

8.3 Document Management.
The Contractor must retain sufficient documentation to substantiate claims for payment under the Contract and all other records, electronic files, papers, and documents that were made in relation to this Contract. The Contractor must retain all documents related to the Contract for five (5) years after expiration of the Contract or, if longer, the period required by the General Records Schedules maintained by the Florida Department of State available at the Department of State's Records Management website.

8.4 Intellectual Property.

8.4.1 Ownership.
Unless specifically addressed otherwise in the Contract, the State of Florida shall be the owner of all intellectual property rights to all property created or developed in connection with the Contract.

8.4.2 Patentable Inventions or Discoveries.
Any inventions or discoveries developed in the course, or as a result, of services in connection with the Contract that are patentable pursuant to 35 U.S.C. § 101 are the sole property of the State of Florida. Contractor must inform the Customer of any inventions or discoveries developed or made through performance of the Contract, and such inventions or discoveries will be referred to the Florida Department of State for a determination on whether patent protection will be sought. The State of Florida will be the sole owner of all patents resulting from any invention or discovery made through performance of the Contract.

8.4.3 Copyrightable Works.
Contractor must notify the Department or State of Florida of any publications, artwork, or other copyrightable works developed in connection with the Contract. All copyrights created or developed through performance of the Contract are owned solely by the State of Florida.

SECTION 9. DATA SECURITY.

The Contractor will maintain the security of State of Florida data including, but not limited to, maintaining a secure area around any displayed visible data and ensuring data is stored and secured when not in use. The Contractor and subcontractors will not perform any of the services from outside of the United States, and the Contractor will not allow any State of Florida data to be sent by any medium, transmitted, or accessed outside the United States due to Contractor's action or inaction. In the event of a security breach involving State of Florida data, the Contractor shall give notice to the Customer and the Department within one business day. "Security breach" for purposes of this section will refer to a confirmed event that compromises the confidentiality, integrity, or availability of data. Once a data breach has been contained, the Contractor must provide the Department with a post-incident report documenting all containment, eradication, and recovery measures taken. The Department reserves the right in its sole discretion to enlist a third party to audit Contractor's findings and produce an independent report, and the Contractor will fully cooperate with the third party. The Contractor will also comply with all HIPAA requirements and any other state and federal rules and regulations regarding security of information.

SECTION 10. GRATUITIES, LOBBYING, AND COMMUNICATIONS.

10.1 Gratuities.
The Contractor will not, in connection with this Contract, directly or indirectly (1) offer, give, or agree to give anything of value to anyone as consideration for any State of Florida officer's or employee's decision, opinion, recommendation, vote, other exercise of discretion, or violation of a known legal duty, or (2) offer, give, or agree to give to anyone anything of value for the benefit of, or at the direction or request of, any State of Florida officer or employee.

10.2 Lobbying.
In accordance with sections 11.062 and 216.347, F.S., Contract funds are not to be used for the purpose of lobbying the Legislature, the judicial branch, or the Department. Pursuant to section 287.058(6), F.S., the Contract does not prohibit the Contractor from lobbying the executive or legislative branch concerning the scope of services, performance, term, or compensation regarding the Contract after the Contract is executed and during the Contract term.

10.3 Communications.

10.3.1 Contractor Communication or Disclosure.
The Contractor shall not make any public statements, press releases, publicity releases, or other similar communications concerning the Contract or its subject matter or otherwise disclose or permit to be disclosed any of the data or other information obtained or furnished in compliance with the Contract, without first notifying the Customer's Contract Manager and securing the Customer's prior written consent.

10.3.2 Use of Customer Statements.
The Contractor shall not use any statement attributable to the Customer or its employees for the Contractor's promotions, press releases, publicity releases, marketing, corporate communications, or other similar communications, without first notifying the Customer's Contract Manager and securing the Customer's prior written consent.

SECTION 11. CONTRACT MONITORING.

11.1 Performance Standards.
The Contractor agrees to perform all tasks and provide deliverables as set forth in the Contract. The Department and the Customer will be entitled at all times, upon request, to be advised as to the status of work being done by the Contractor and of the details thereof.

11.2 Performance Deficiencies and Financial Consequences of Non-Performance.

11.2.1 Proposal of Corrective Action Plan.
In addition to the processes set forth in the Contract (e.g., service level agreements), if the Department or Customer determines that there is a performance deficiency that requires correction by the Contractor, then the Department or Customer will notify the Contractor. The correction must be made within a time-frame specified by the Department or Customer. The Contractor must provide the Department or Customer with a corrective action plan describing how the Contractor will address all performance deficiencies identified by the Department or Customer.

11.2.2 Retainage for Unacceptable Corrective Action Plan or Plan Failure.
If the corrective action plan is unacceptable to the Department or Customer, or implementation of the plan fails to remedy the performance deficiencies, the Department or Customer will retain ten percent (10%) of the total invoice amount. The retainage will be withheld until the Contractor resolves the performance deficiencies. If the performance deficiencies are resolved, the Contractor may invoice the Department or Customer for the retained amount. If the Contractor fails to resolve the performance deficiencies, the retained amount will be forfeited to compensate the Department or Customer for the performance deficiencies.

11.3 Performance Delay.

11.3.1 Notification.
The Contractor will promptly notify the Department or Customer upon becoming aware of any circumstances that may reasonably be expected to jeopardize the timely and successful completion (or delivery) of any commodity or contractual service. The Contractor will use commercially reasonable efforts to avoid or minimize any delays in performance and will inform the Department or the Customer of the steps the Contractor is taking or will take to do so, and the projected actual completion (or delivery) time. If the Contractor believes a delay in performance by the Department or the Customer has caused or will cause the Contractor to be unable to perform its obligations on time, the Contractor will promptly so notify the Department and use commercially reasonable efforts to perform its obligations on time notwithstanding the Department’s delay.

11.3.2 Liquidated Damages.
The Contractor acknowledges that delayed performance will damage the DepartmentCustomer, but by their nature such damages are difficult to ascertain. Accordingly, the liquidated damages provisions stated in the Contract documents will apply. Liquidated damages are not intended to be a penalty and are solely intended to compensate for damages.

11.4 Force Majeure, Notice of Delay, and No Damages for Delay.

The Contractor will not be responsible for delay resulting from its failure to perform if neither the fault nor the negligence of the Contractor or its employees or agents contributed to the delay, and the delay is due directly to fire, explosion, earthquake, windstorm, flood, radioactive or toxic chemical hazard, war, military hostilities, terrorism, civil emergency, embargo, riot, strike, violent civil unrest, or other similar cause wholly beyond the Contractor's reasonable control, or for any of the foregoing that affect subcontractors or suppliers if no alternate source of supply is available to the Contractor. The foregoing does not excuse delay which could have been avoided if the Contractor implemented any risk mitigation required by the Contract. In case of any delay the Contractor believes is excusable, the Contractor will notify the Department in writing of the delay or potential delay and describe the cause of the delay either (1) within ten (10) calendar days after the cause that created or will create the delay first arose, if the Contractor could reasonably foresee that a delay could occur as a result, or (2) if delay is not reasonably foreseeable, within five (5) calendar days after the date the Contractor first had reason to believe that a delay could result. The foregoing will constitute the Contractor's sole remedy or excuse with respect to delay. Providing notice in strict accordance with this paragraph is a condition precedent to such remedy. No claim for damages will be asserted by the Contractor. The Contractor will not be entitled to an increase in the Contract price or payment of any kind from the Department for direct, indirect, consequential, impact or other costs, expenses or damages, including but not limited to costs of acceleration or inefficiency, arising because of delay, disruption, interference, or hindrance from any cause whatsoever. If performance is suspended or delayed, in whole or in part, due to any of the causes described in this paragraph, after the causes have ceased to exist the Contractor will perform at no increased cost, unless the Department determines, in its sole discretion, that the delay will significantly impair the value of the Contract to the State of Florida or to Customers, in which case the Department may (1) accept allocated performance or deliveries from the Contractor, provided that the Contractor grants preferential treatment to Customers and the Department with respect to commodities or contractual services subjected to allocation, or (2) purchase from other sources (without recourse to and by the Contractor for the related costs and expenses) to replace all or part of the commodity or contractual services that are the subject of the delay, which purchases may be deducted from the Contract quantity, or (3) terminate the Contract in whole or in part.

SECTION 12. CONTRACT AUDITS.

12.1 Performance or Compliance Audits.
The Department may conduct or have conducted performance and/or compliance audits of the Contractor and subcontractors as determined by the Department. The Department may conduct an audit and review all the Contractor's and subcontractors' data and records that directly relate to the Contract. To the extent necessary to verify the Contractor's fees and claims for payment under the Contract, the Contractor's agreements or contracts with subcontractors, partners, or agents of the Contractor, pertaining to the Contract, may be inspected by the Department upon fifteen (15) calendar days' notice, during normal working hours and in accordance with the Contractor's facility access procedures where facility access is required. Release statements from its subcontractors, partners, or agents are not required for the Department or its designee to conduct compliance and performance audits on any of the Contractor's contracts relating to this Contract. The Inspector General, in accordance with section 5.6, the State of Florida's Chief Financial Officer, the Office of the Auditor General also have authority to perform audits and inspections.

12.2 Payment Audit.
Records of costs incurred under terms of the Contract will be maintained in accordance with section 8.3 of these Special Contract Conditions. Records of costs incurred will include the Contractor's general accounting records, together with supporting documents and records of the Contractor and all subcontractors performing work, and all other records of the Contractor and subcontractors considered necessary by the Department, the State of Florida's Chief Financial Officer, or the Office of the Auditor General.

SECTION 13. BACKGROUND SCREENING AND SECURITY.

13.1 Background Check.
The Department or Customer may require the Contractor to conduct background checks of its employees, agents, representatives, and subcontractors as directed by the Department or Customer. The cost of the background checks will be borne by the Contractor. The Department or Customer may require the Contractor to exclude the Contractor's employees, agents, representatives, or subcontractors based on the background check results. In addition, the Contractor must ensure that all persons have a responsibility to self-report to the Contractor within three (3) calendar days any arrest for any disqualifying offense. The Contractor must notify the Contract Manager within twenty-four (24) hours of all details concerning any reported arrest. Upon the request of the Department or Customer, the Contractor will re-screen any of its employees, agents, representatives, and subcontractors during the term of the Contract.

13.2 E-Verify.
The Contractor must use the U.S. Department of Homeland Security's E-Verify system to verify the employment eligibility of all new employees hired during the term of the Contract for the services specified in the Contract. The Contractor must also include a requirement in subcontracts that the subcontractor must utilize the E-Verify system to verify the employment eligibility of all new employees hired by the subcontractor during the Contract term. In order to implement this provision, the Contractor must provide a copy of its DHS Memorandum of Understanding (MOU) to the Contract Manager within five (5) calendar days of Contract execution. If the Contractor is not enrolled in DHS E-Verify System, it will do so within five (5) calendar days of notice of Contract award and provide the Contract Manager a copy of its MOU within five (5) calendar days of Contract execution. The link to E-Verify is https://www.uscis.gov/e-verify. Upon each Contractor or subcontractor new hire, the Contractor must provide a statement within five (5) calendar days to the Contract Manager identifying the new hire with its E-Verify case number.

13.3 Disqualifying Offenses.
If at any time it is determined that a person has been found guilty of a misdemeanor or felony offense as a result of a trial or has entered a plea of guilty or nolo contendere, regardless of whether adjudication was withheld, within the last six (6) years from the date of the court's determination for the crimes listed below, or their equivalent in any jurisdiction, the Contractor is required to immediately remove that person from any position with access to State of Florida data or directly performing services under the Contract. The disqualifying offenses are as follows:

(a) Computer related crimes;
(b) Information technology crimes;

(c) Fraudulent practices;
(d) False pretenses;
(e) Frauds;
(f) Credit card crimes;
(g) Forgery;
(h) Counterfeiting;
(i) Violations involving checks or drafts;
(j) Misuse of medical or personnel records; and
(k) Felony theft.

13.4 Confidentiality.
The Contractor must maintain confidentiality of all confidential data, files, and records related to the commodities or contractual services provided pursuant to the Contract and must comply with all state and federal laws, including, but not limited to sections 381.004, 384.29, 392.65, and 456.057, F.S. The Contractor's confidentiality procedures must be consistent with the most recent version of the Department security policies, protocols, and procedures. The Contractor must also comply with any applicable professional standards with respect to confidentiality of information.

SECTION 14. WARRANTY OF CONTRACTOR'S ABILITY TO PERFORM.

The Contractor warrants that, to the best of its knowledge, there is no pending or threatened action, proceeding, or investigation, or any other legal or financial condition, that would in any way prohibit, restrain, or diminish the Contractor's ability to satisfy its Contract obligations. The Contractor warrants that neither it nor any affiliate is currently on the Suspended Vendor List, Convicted Vendor List, or the Discriminatory Vendor List, or on any similar list maintained by any other state or the federal government. The Contractor shall immediately notify the Department in writing if its ability to perform is compromised in any manner during the term of the Contract.

Exhibit B

Benefits Consulting, Actuarial, and Claims Auditing Services Request for Proposals

No. 19-80111502-A

Addendum No. 2 – Timeline and RFP Revision

Contained herein are revisions to the timeline and RFP. The Department hereby amends RFP No. 19-80111502-A as noted within this Addendum. All revisions are underlined or in strikethrough and are highlighted. In the event of a conflict between information contained in RFP No. 19-80111502-A previously released on the Vendor Bid System on July 30, 2019, and the information contained herein, the information herein shall control. The information included in this addendum is now made part of this RFP No. 19-80111502-A solicitation. Please Note: This Addendum No. 2 does not need to be returned with a vendor's proposal.

1. The timeline is revised as follows:

Timeline of Events

The table below contains the timeline of events for this solicitation. It is the responsibility of the Respondent to check for any changes. The dates and times within the Timeline of Events may be subject to change. All changes to the Timeline of Events will occur through an addendum to the solicitation and will be noticed on the Vendor Bid System (VBS).

Respondents shall not rely on the MyFloridaMarketPlace (MFMP) Sourcing time clock. It is not the official submission date and time deadline. The official solicitation closing time and deadlines are reflected in the Timeline of Events listed below.

Timeline of Events	Event Time (Eastern Time)	Event Date
Solicitation posted on the VBS and in MFMP Sourcing		7/30/2019
Deadline to submit questions in MFMP Sourcing	10:00 AM	8/12/2019
Department's anticipated posting of answers on the VBS		8/27/2019
Deadline to submit proposal and all required documents in MFMP Sourcing	10:00 AM	9/10/2019
Public Opening Meeting location: 4050 Esplanade Way, Room 101, Tallahassee, FL 32399-0950	10:30 AM	9/10/2019
Formal evaluations conducted		9/24/2019-10/31/2019

Timeline of Events	Event Time (Eastern Time)	Event Date
~~Public Meeting for Evaluators to confirm technical scores~~ ~~Meeting location: 4050 Esplanade Way, Room 101, Tallahassee, FL 32399-0950~~	~~10:00 AM~~	~~11/12/2019~~
Anticipated date to post Notice of Intent to Award		11/19/2019
Anticipated Contract start date		12/17/2019

2. Section 5.4 of the RFP is revised as follows:

5.4 Technical Evaluation ~~and Evaluator's Public Meeting~~

The Evaluators will independently review and score the responsive and responsible technical proposals using the evaluation criteria described in Attachment D - Technical Proposal and Technical Proposal Evaluation Criteria. ~~The Department will then hold a public meeting in which the evaluators will confirm their technical scores in accordance with the Timeline of Events.~~

FAILURE TO FILE A PROTEST WITHIN THE TIME PRESCRIBED IN SECTION 120.57(3), FLORIDA STATUTES, OR FAILURE TO POST THE BOND OR OTHER SECURITY REQUIRED BY LAW WITHIN THE TIME ALLOWED FOR FILING A BOND SHALL CONSTITUTE A WAIVER OF PROCEEDINGS UNDER CHAPTER 120, FLORIDA STATUTES.

Any protest must be timely filed with the Department of Management Services' Agency Clerk. Protests may be filed by courier, hand delivery, or U.S. mail at Department of Management Services, Office of the General Counsel, Attention: Agency Clerk, 4050 Esplanade Way, Suite 160, Tallahassee, FL 32399-0950. Protests may also be filed by fax at 850-922-6312 or by email at agencyclerk@dms.myflorida.com. It is the filing party's responsibility to meet all filing deadlines.

Benefits Consulting, Actuarial, and Claims Auditing Services
Request for Proposals

No. 19-80111502-A

Addendum No. 1 – RFP Revisions and Questions and Answers

Contained herein are revisions to the RFP, attachments, and the answers to the questions timely submitted to the Department of Management Services (Department). The Department hereby amends RFP No. 19-80111502-A as noted within this Addendum. All revisions are underlined or in strikethrough and are highlighted. In the event of a conflict between information contained in RFP No. 19-80111502-A previously released on the Vendor Bid System on July 30, 2019, and the information contained herein, the information herein shall control. The information included in this addendum is now made part of this RFP No. 19-80111502-A solicitation. Please Note: This Addendum No. 1 does not need to be returned with a vendor's proposal.

1. RFP No. 19-80111502-A is hereby amended as follows:
   a. Attachment D, Technical Proposal and Technical Proposal Evaluation Criteria, is replaced in its entirety with the Attachment D, Revised Technical Proposal and Technical Proposal Evaluation Criteria, which is posted on the Vendor Bid System.

   b. Attachment E, Responsive Requirements, is replaced in its entirety with the Attachment E, Revised Responsive Requirements, which is posted on the Vendor Bid System.

   c. Subsection 1.6, Order of Precedence for Solicitation, is amended as follows:
   In the event of a conflict, the conflict will be resolved in the following order of priority (highest to lowest):
   a) Addenda to Solicitation, if issued (in reverse order of issuance)
   b) Cost Proposal, Attachment A
   c) Special Contract Conditions, Attachment B
   d) Draft Contract, Attachment C
   e) Revised Technical Proposal and Technical Proposal Evaluation Criteria, Attachment D
   f) RFP all other RFP attachments

   d. Subsection 2.1.1, Service Category 1 – Benefits Consulting, is amended as follows: Awarded Contractor(s) will provide services related to~~,~~ and/or advise Customers on~~, insurance and/or~~ employee benefits. This includes providing a range of advice, assistance, guidance, counseling, and support on selecting, purchasing, and administering employee benefits.

   e. Subsection 2.5.1, Tasks, is amended as follows:
   2.5.1.1 Tasks Applicable to all Service Categories. Tasks that may be permissible under this Contract include, but are not limited to:

      - Provide legislative support, including, but not limited to, presentation(s) to legislative staff, and any requested analyses.
      - Provide testimony as a witness in a court proceeding.
      - Review proposed legislation and determine potential program impacts.
      - Prepare fiscal impact notes and bill analyses.
      - Consult or advise Customer by phone, letter, email, or in person.
      - Conduct or assist presentations as requested.
      - Perform special projects, special studies, and special evaluations as needed.
      - Assist with the development and implementation of an educational and outreach strategy.
      - ~~Create and disseminate various educational materials, brochures, flyers (hard copy and online).~~

- ~~Perform reviews of actuarial valuations and impact statements.~~
- Review content and create necessary reports.
- Verify validity of reports and calculations.

f. Subsection 4.1.2, Attachment E – Responsive Requirements, is amended as follows:
4.1.2 Attachment E – Responsive Requirements
The Respondent must submit a completed Attachment E – Revised Responsive Requirements document.

g. Subsection 5.4, Technical Evaluation and Evaluator's Public Meeting, is amended as follows:
The Evaluators will independently review and score the responsive and responsible technical proposals using the evaluation criteria described in Attachment D - Revised Technical Proposal and Technical Proposal Evaluation Criteria. The Department will then hold a public meeting in which the evaluators will confirm their technical scores in accordance with the Timeline of Events.

h. Subsection 5.5, Basis of Award, is amended as follows:
Contract(s) will be awarded to the responsive and responsible Vendor(s) per Service Category that is determined to be the most advantageous to the state with the highest Service Category total final score. The Department will issue an award per Service Category (i.e. 1) Benefits Consulting Services, 2) Actuarial Services, and 3) Claims Auditing Services) to the vendor with the highest Service Category total final score, which will be calculated by the Procurement Officer by combining the average of the evaluator technical scores for a Service Category and the cost proposal score. A Contract for a Service Category will be awarded to the responsive and responsible Respondent(s) whose proposal for a Service Category is determined in writing to be the most advantageous to the State, taking into consideration the price and other criteria set forth in this RFP. The Department will consider the total cost for each year of the Contract, including initial and renewal years as submitted by the Respondent. The Department reserves the right to make multiple awards per Service Category to Respondents whose total final score is within 20% of the highest total final score for that Service Category. The methodology for scoring each Service Category is outlined below:

Proposal	Available Points
A. Technical Proposal (Attachment D)	**130**
B. Cost Proposal (Attachment A)	**70**
Total Available Points for a Service Category (A + B)	**200**

A Respondent may receive awards for multiple proposed Service Categories in accordance with the terms of the RFP. The Department reserves the right to award multiple Contracts, for all or part of the work contemplated by this solicitation. The Department reserves the right to accept or reject any and all offers, and to waive any minor irregularity, technicality, or omission if the Department determines that doing so will serve the best interest of the state. However, the Department reserves the right to make no award in one or all Service Categories as determined to be in the best interest of the State.

i. Subsection 5.5.1 is amended as follows:

The Respondent shall be awarded up to 130 points for a Service Category based on its submitted Technical Proposal in accordance with the evaluation criteria outlined in Attachment D - Revised Technical Proposal and Technical Proposal Evaluation Criteria.

j. Page 27 of the RFP, RFP Attachments, is amended as follows:
Attachment A - Cost Proposal (must be submitted prior to RFP opening)
Attachment B – Special Contract Conditions
Attachment C – Draft Contract
Attachment D – Revised Technical Proposal and Technical Proposal Evaluation Criteria (vendor response must be submitted prior to RFP opening)
Attachment E – Revised Responsive Requirements (must be submitted prior to RFP opening)
Attachment F – Vendor Information
Attachment G – No Offshoring
Attachment H – Certification of Drug-Free Workplace
Attachment I – Subcontracting

2. The Department's responses to timely submitted questions are below:

No.	Question	Answer
1.	Who is/are the incumbent consultant(s) and how long have they been in place?	The services sought in this procurement are not currently provided as a state term contract for the State of Florida. The Department of Management Services, Division of State Group Insurance has the following current contracts: DMS 13/14-018A with Foster and Foster to provide an independent benefits consultant, actuarial and auditing services; DMS 13/14-018B with Gabriel, Roeder and Smith to provide an independent benefits consultant, actuarial and auditing services and DMS 13/14-018C with Mercer to provide an independent benefits consultant, actuarial and auditing services. The contract effective dates for the Division of State Group Insurance contracts are: DMS 13/14-018A: 7/23/2014 DMS 13/14-018B: 8/29/2014 DMS 13/14-018C: 7/23/2014 The Department of Management Services, Division of Retirement has the following current contracts: DMS 17/18-004 with Gabriel, Roeder and Smith and DMS 10/11-015 with Milliman to provide actuarial services. The contract effective dates for the Division of Retirement contracts are: DMS 17/18-004: 9/18/2018 DMS 10/11-015: 7/1/2011
2.	Why did DMS decide to bid these services at this time?	Reference RFP subsection 1.1, Objective.

3.	Are the services outlined in RFP comparable to those currently being provided by the incumbent consultant(s)?	The services sought in this procurement are not currently provided as a state term contract for the State of Florida. The Department's current contracts for independent benefits consultant, actuarial and auditing services are specific to the Department's needs. The three service categories have been broadened for this procurement to accommodate the needs of multiple customers under the awarded state term contract(s).
4.	What were the total consulting fees for these services during each of the last three years? What were the fees by Service Category – Benefits Consulting, Actuarial, and Claim Audit?	Reference RFP subsection 1.2, Background Information. The services sought in this procurement are not currently provided as a state term contract for the State of Florida. For the Department of Management Services, Division of State Group Insurance, the fees by Service Category are as follows: Independent Benefits Consultant – Fiscal Year 2016-2017 approximately $734,000; Fiscal Year 2017-2018 approximately $610,000; and Fiscal Year 2018-2019, approximately $551,000. Actuarial Services – Fiscal Year 2016-2017 approximately $20,000; Fiscal Year 2017-2018 approximately $54,000; and Fiscal Year 2018-2019 approximately $37,000. Auditing Services – Fiscal Year 2016-2017 approximately $142,000; Fiscal Year 2017-2018 approximately $128,000; and Fiscal Year 2018-2019 approximately $95,000. For the Department of Management Services, Division of Retirement, the fees by Service Category are as follows: Independent Benefits Consultant – Fiscal Year 2016-2017 approximately $25,000; Fiscal Year 2017-2018 approximately $25,000; and Fiscal Year 2018-2019 approximately $25,000.Actuarial Services – Fiscal Year 2016-2017 approximately $190,000; Fiscal Year 2017-2018 approximately $76,000; and Fiscal Year 2018-2019 approximately $180,000.
5.	What were the total number of consulting hours for these services during each of the last three years? What were the hours by Service Category – Benefits Consulting, Actuarial, and Claim Audit?	The services sought in this procurement are not currently provided as a state term contract for the State of Florida. For the Department of Management Services, this information is unknown at this time.
6.	When do you anticipate each in-scope coverage (e.g., medical, dental, etc.) will next go out to bid?	Upon award of resultant Contract(s), Customers can create a customer-specific scope of work on an as needed basis.

7.	Have there been any major changes to the employee benefit programs in the last three years? If so, please describe the changes and their impact.	The services sought in this procurement are not currently provided as a state term contract for the State of Florida. For the Department of Management Services, Division of State Group Insurance, the last three years the Florida Legislature has made substantial changes to the State Group Insurance Program (Program), including requiring the Department to procure and implement three new benefits: an online transparency portal to allow employees to shop for healthcare services by cost and quality, a bundled medical services provider, and an administrator of a health reimbursement account. These benefits comprise the state's Shared Savings Program. With the help of benefits consultants, the Department conducted a comprehensive review of the Program, including a benchmarking analysis, and issued recommendations to the Legislature for implementation of metal tier-style health plans. In addition, the Department conducted a statewide dependent eligibility verification audit, implemented a weight management pilot, procured for Medicare-Advantage Prescription Drug plans, recently initiated a referral pattern analysis with a benefits consultant to help to set up regions for HMO services by rule, and is also implementing formulary management for the 2020 plan year.
8.	How many subscribers and members are covered under medical, dental, vision, life, etc.? Please also provide subscribers and members by plan option for each coverage.	A list of subscribers can be found in Exhibit 1 to Addendum 1. A listing of subscribers and members by plan option for each coverage type does not exist.
9.	How many claims audits do you anticipate to be performed annually under this contract and of which vendors?	The services sought in this procurement are for statewide use by any eligible Customer. For any resultant contract(s), needs and services will be determined by the Customers.
10.	What type of data will the selected consultant have access to and how will they receive it?	The type of data is dependent upon the type of Customer and the Customer's needs. For the Department of Management Services, Division of State Group Insurance, aggregate medical and pharmacy claims data can be provided for analyses.
11.	Will the selected consultant(S) be required to receive and/or store PHI or other confidential data from DMS?	The services sought in this procurement are for statewide use by any eligible Customer. For any resultant contract(s), needs and services will be determined by the Customers.
12.	Does the State of Florida currently have a health care data warehouse in place? If so, who is the data warehouse vendor and how many years of data are currently available?	The State of Florida does not have a contract for storing State of Florida health care data, however the Department of Management Services, Division of State Group Insurance has a contract with Benefitfocus to store health care data for members of the State Employees' Group Health Insurance Program. The Program covers all State agencies, State universities, a handful of other entities, and enrolled retirees. Health care data is available from January 2012 to present.

13.	Please confirm whether DMS prefers a single Technical Proposal narrative that spans the requirements of all Service Categories being proposed on or a separate narrative by Service Category?	See the posted Attachment D, Revised Technical Proposal and Technical Proposal Evaluation Criteria.
14.	Is there additional guidance DMS can provide regarding the content of the Technical Proposal, for example, is there interest in client references?	See the response to question 13.
15.	What are the most important challenges facing your program that you wish to address through this contract?	See the response to question 2 and question 11. The Department relies on an independent benefits consultant(s) to help quantify and qualify member and financial impacts of benefit changes, as well as ensure fiscal integrity and accountability in its programs.
16.	The last two bullets in RFP section 2.4.3 are typically requirements associated with vendors that conduct financial audits. Given that Service Category 3 refers to operational and claims audits of the State's third-party administrators which do not constitute a financial audit in the traditional sense, please confirm whether these requirements/preferences apply.	Yes, the last two bullets in RFP subsection 2.4.3 are applicable to Service Category 3 – Claims Auditing Services.
17.	We request that the last paragraph of Section 2.1 of the RFP be modified as follows, to clarify that the Contractor and Customers can expressly agree to specific modifications to the terms and conditions established by the master contract, and those express agreements shall not be considered a "conflict" as that term is used elsewhere in the provision: When creating a Customer specific scope of work, Customers are permitted to negotiate terms and conditions which supplement those contained in this Contract. Such additional terms shall be for similar or equivalent services contemplated in this Contract Scope of Work and shall not conflict with the terms and	RFP subsection 2.1 will not be modified.

	conditions established by this Contract (and any such conflicting terms shall be resolved in favor of terms most favorable to the Customer). Notwithstanding the foregoing, the Customer and Contractor can agree within a Customer's scope of work, with express reference to specific sections in this Contract, to modify terms of this Contract and such modifications will not be considered a "conflict" under this paragraph. Specific terms and conditions within a Customer's scope of work are only applicable to the Customer's Contract or Purchase Order. Alternatively, if the Department does not agree to modify Section 2.1 of the RFP as set forth above, we request the Department modify the RFP to permit an offeror to submit terms and conditions exceptions as part of its proposal. Examples of sections that would require modification to account for an exception process include Section 3.5 and Section 6.1.	
18.	Please confirm if the State is willing to accept the Auto Liability based on Auto limits on any one accident or loss?	No, the state is not willing to accept the Auto Liability based on Auto limits on any one accident or loss.
19.	Please confirm if the State is willing to accept that our professional liability limits are each wrongful act/annual aggregate and our policy has a $5 million retention. Our annual report is available online for the State to review.	Reference Attachment B, Special Contract Conditions, Section 7, Liability and Insurance, for insurance requirements. Also, the services sought in this procurement are for statewide use by any eligible Customer who may, when creating a Customer specific scope of work, negotiate terms and conditions which supplement those contained in the Contract.
20.	With regards to WOS we would request that the waiver of the insurer's subrogation rights with WC, EL, GL and Al be removed or if not, will the State allow mutual waivers under the other party's policies?	This question is not clear. See the response to question 19.
21.	Please confirm if the State would allow the Awardee to advise that a cancelled, or non-renewed policy would be replaced with no coverage	Yes, reference Attachment B, Special Contract Conditions, subsection 7.3, Florida Authorized Insurers. The Department requires a current certificate of insurance (COI).

	gap and a current COI would be provided and not provide a cancellation notice, since coverage will be replaced with no gap.	
22.	Please confirm that it is acceptable to name the State as an additional insured on our Commercial General Liability Policy, but it will be via a Certificate of Insurance, not endorsement? Is this acceptable to the State?	Reference Attachment B, Special Contract Conditions, subsection 7.3, Florida Authorized Insurers.
23.	Section 7.4 Performance Bond – Will a performance bond be required for this State Term Contract? If so, for what amount?	No, a performance bond is not required for a Contractor awarded a Contract for this procurement.
24.	Section 7.5 and 7.6 Indemnification: Please confirm if the State is willing to accept the indemnification be limited to losses and damages as a result of our negligence and covered under the terms of our general liability policy; any wrongful acts solely in rendering or failing to render professional services and covered under our professional liability policy; or, any claim alleging a security failure, privacy event or wrongful act and covered under our cyber liability policy (misappropriation of trade secret or, infringement of patent are exclusions in our cyber policy)	Attachment B, Special Contract Conditions will remain as written. Please reference RFP subsection 6.1, General Instructions, the modification to Section 9 of the PUR1001 which contains a Respondent's Representations and Authorizations in submitting a response. Also see the posted Attachment E, Revised Responsive Requirements.
25.	Section 8.4 Intellectual Property - This section should make clear that we will retain sole and exclusive ownership of all right, title and interest in and to its intellectual property and derivatives thereof which no data or confidential information of the State was used to create and which was developed entirely using our own resources. To the extent our intellectual property is necessary for the State to use the services provided, we will grant to the State a non-exclusive, royalty-free license to our intellectual property solely for the State's use of such services.	Attachment B, Special Contract Conditions will remain as written.

26.	Page 6 – Introduction and Objective Section – How many state term contracts will be awarded through this RFP? Is the state looking for multiple consultants or just one?	Reference RFP subsection 1.1, Objective, and subsection 5.5, Basis of Award.
27.	Page 15 – Diversity Report – Is the State looking for the awardee to include certified and other minority business enterprises? If yes, what has been the percentage of the contract provided towards these vendors?	Reference RFP subsection 3.9, Commitment to Diversity in Government Contracting. RFP subsection 2.13 references reporting requirements for awarded Contractor(s).
28.	Can you provide the current agreements and annual compensation of the incumbent insurance consultants?	See response to question 1. Current Department of Management Services contracts can be found on the Florida Accountability Contract Tracking System: https://facts.fldfs.com/Search/ContractSearch.aspx
29.	RFP Due Date: Would the State consider extending the closing date?	No, the Department has a firm timeline.
30.	Please confirm that Section 19 (Indemnification) of the PUR 1000 General Contract Conditions will pertain to contracts awarded under RFP No: 19-80111502-A for Benefits Consulting, Actuarial, and Claims Auditing Services. Retaining this language in the contract is important for our organization's ability to respond to the RFP.	No. The PUR 1000 is superseded in its entirety by the Special Contract Conditions. Reference Attachment B, Special Contract Conditions, Table of Contents, and subsection 7.5, Indemnification.
31.	Please confirm that Section 20 (Limitation of Liability) of the PUR 1000 General Contract Conditions will pertain to contracts awarded under RFP No: 19-80111502-A for Benefits Consulting, Actuarial, and Claims Auditing Services. Retaining this language in the contract is important for our organization's ability to respond to the RFP.	No. The PUR 1000 is superseded in its entirety by the Special Contract Conditions. Reference Attachment B, Special Contract Conditions, Table of Contents, and subsection 7.6, Limitation of Liability.
32.	Please confirm that Section 31 (Dispute Resolution) of the PUR 1000 General Contract Conditions will pertain to contracts awarded under RFP No: 19-80111502-A for Benefits Consulting, Actuarial, and Claims Auditing Services. Retaining this language in the contract is important for our organization's ability to respond to the RFP.	No. The PUR 1000 is superseded in its entirety by the Special Contract Conditions. Reference Attachment B, Special Contract Conditions, Table of Contents, and subsection 5.2, Dispute Resolution, Governing Law, and Venue. Also, see the response to question 13.

	Attachment D, Section 2 (Proposed Solution) states: "The Respondent shall fully describe in the Technical Proposal their solution for carrying out the proposed Service Category(ies) which demonstrates the Respondent's ability to provide the services for which Respondent is submitting a Proposal, including the ability to provide the services statewide." There are a wide range of projects that may fit into the broad categories of Benefits Consulting, Actuarial, and Claims Auditing Services. Since there are no concrete projects listed in the RFP, should respondents describe their general approach for providing typical services in each category?	
33.	Has the Department previously engaged consulting companies to perform similar tasks? If yes, please provide a sample of the work product including reports, outlines of presentations to be given to legislative bodies, etc.	For the Department of Management Services, the following companies have been contracted to perform similar tasks: Mercer, Foster & Foster, Milliman, and Gabriel, Roeder, Smith & Company. Current Department of Management Services contracts, and the applicable terms and conditions, can be found on the Florida Accountability Contract Tracking System: https://facts.fldfs.com/Search/ContractSearch.aspx. The question is unclear what specific documents are being requested. Public records requests can be submitted to: publicrecords@dms.myflorida.com.
34.	There are three categories within the RFP: 1) Benefits Consulting; 2) Actuarial Services; and 3) Claims Auditing Services: Will any preference be given to a respondent who proposes to offer services in all three service categories?	No preference will be given to vendors who propose all three Service Categories.
35.	Section 2.5.1.4 Service Category 3 – Claims Auditing Tasks: among others that the tasks that may be permissible for Service Category 3 include, but are not limited to: "Audit Customer information processed during the audit period"	The services sought in this procurement are for statewide use by any eligible Customer. Customer information and the time period(s) will be defined by the Customer specific scope of work. The Department of Management Services Division of State Group Insurance has previously requested post payment audits of medical and pharmacy claims.

	Please provide a sample or further explanation of "Customer information" What time period(s) would be subject to "Audit"?	The Department of Management Services has previously defined an audit period as July 1st through June 30th of a year.
36.	What is the anticipated delivery deadline of a work product from a respondent subsequent to the conclusion of an audit period?	The services sought in this procurement are for statewide use by any eligible Customer. Timelines and deliverables will be defined by the Customer specific scope of work.
37.	Can you please provide details on the evaluation criteria for relevant Experience? As this is worth 75/130 points for the technical proposal, we would like to understand what specific information is required to confirm extensive relevant experience.	See the response to question 13.
38.	Can you please provide further detail on the evaluation criteria for Proposed Solution? The service categories, particularly "Benefits Consulting Services" are broad, and this aspect of these proposal consists of one open-ended question. Can you identify the specific benefits consulting services that The State of Florida will base the evaluation on? How will "exceptional ability to provides the services" be determined?	See the response to question 13.
39.	What are your top 5 objectives/priorities for benefit consulting services?	See the response to question 11. For the Department of Management Services, Division of State Group Insurance, priorities include, but are not limited to: consulting support for procurements related to Pharmacy Benefits Management Services, Health Maintenance Organization, and Preferred Provider Organization services; benchmarking and trend analyses; actuarial and financial analyses; plan design analyses; and claims, program, and financial audits. For the Department of Management Services, Division of Retirement, priorities include, but are not limited to, actuarial and financial analyses and plan design analyses.
40.	Are there existing State contracts with benefits consulting companies? If yes, do they reflect the services	See the response to question 28.

	requested in this RFP? If yes, may we review them?	
41.	RFP pages 10-11Section 2.5.1. 2.5.1.1 Tasks Applicable to all Service Categories. Not all of the stated tasks applicable to all Service Categories seem to fit for Service Category 3 Claims Auditing specifically. Can you clarify if the following tasks will be expected for Service Category 3: Create and disseminate various educational materials brochures, flyers (hard copy and online) Perform reviews of actuarial valuations and impact statements.	See Addendum 1, 1.d., revised sub-section 2.5.1.1, listed above.
42.	The RFP does not provide a required response format. Please describe what needs to be included in the Technical proposal besides Attachment D. For example, does the State want vendors to also provide organizational background information and/or references? Does it matter what proposal order we provide our Experience and Proposed Solution (Attachment D)?	See the response to question 13.
43.	Is it the State's intent to award this work to different vendors? Who is the incumbent of the current contract?	See the response to question 1 and question 26.
44.	Please list the entities (customers) that can utilize this contract and is it primarily for the state health plan? On page 6, the State says " Customers for this Contract include state agencies and eligible users". Please provide a list of the eligible users.	Customers include state agencies and eligible users. Agency is defined in section 287.012, Florida Statutes. Eligible Users is defined in Rule 60A- Florida Administrative Code.
45.	What is the audit period?	The services sought in this procurement are for statewide use by any eligible Customer. Customer information and the time period(s) for audits will be defined by the Customer specific scope of work. The Department of Management Services has previously defined an audit period as July 1st through June 30th of a year.

46.	Are there any audit restrictions?	The services sought in this procurement are for statewide use by any eligible Customer. Customer information will be defined by the Customer specific scope of work.
47.	How many members are enrolled in each Plan? · Standard PPO · Health Investor Health Plan PPO	Enrollment in the following plans are as follows as of June 2019: PPO Standard: 81,006 individuals PPO High Deductible Health Plan: 3,220 individuals
48.	Are there performance guarantees in place? If so, are there financial penalties if not met?	Yes, there are financial consequences for the state term contract. Reference RFP subsection 2.8, Financial Consequences. Additionally, Customers may require Customer specific financial consequences for non-performance in a Customer's Request for Quote.
49.	The below section refers to CPA services. Will non CPA firms be considered to conduct the medical claims auditing services? 2.4.3 Service Category 3 – Claims Auditing: External peer reviews are performed of the organization and are in conformance with the peer review standards for the American Institute of Certified Public Accountants and Government Auditing Standards. Principal and Senior auditing personnel have completed at least twenty-four (24) hours of continuing professional education (CPE) within the preceding two (2) years.	The Customer will determine if a CPA is required for Service Category 3. Customer preferences and requirements for each Service Category will be defined by the Customer specific scope of work.
50.	Attachment B - Can the PUR1000 Limitation of Liability (LOL) be acceptable in lieu of what is included in this attachment?	No. The PUR 1000 is superseded in its entirety by the Special Contract Conditions**.** Reference Attachment B, Special Contract Conditions, Subsection 7.6, Limitation of Liability.
51.	Attachment C - Can the order of precedence in the RFP be used in lieu of what is outlined in Attachment C?	RFP subsection 1.6, Order of Precedence for Solicitation, describes how the procurement documents will be resolved in the event of a conflict. Attachment C, Draft Contract, Section III, Contract, describes how the contract attachments will be resolved in the event of a conflict. These two separate orders of priority will remain as stated in the procurement documents.
52.	Specific to service category 3 (claims auditing), what types of entities do you anticipate will be requiring/ requesting these services?	The services sought in this procurement are for statewide use by any eligible Customer. The Department is unsure what types of entities will use Service Category 3. Currently, the Department of Management Services, Division of State Group Insurance uses claims auditing services for

		post payment claims audits of four self-insured medical plans and one pharmacy benefits manager. This category is not currently used by the Department of Management Services, Division of Retirement.
53.	Does the Department have an approximate page # limit for the technical response? Our firm has a lot of specific claims auditing experience and even more experience with closely related services. The response could get lengthy but we do not want to provide too much information so as not to be a burden to the Department in the review process.	See the response to question 13.
54.	Do you expect resumes or bio's to be included as part of the technical proposals? It would seem as though their inclusion would help to highlight that the bidder has the necessary personnel to satisfy the job titles and duties listed in section 2.3 of the RFP, however Attachment D does not mention them in the "experience" section.	See the response to question 13.
55.	Forms to include – In the MFMP portal "submit response" section, it appears that we should upload 7 different files (Attachments A, D, E, F, G, H & I). Can you confirm these are the documents that should be included and that they should be uploaded separately? It appears that all but attachment A would be in PDF and Attachment A would be in excel.	Attachments A, D, E, F, G, H (if applicable), and I are to be uploaded separately into the MFMP portal. Also reference RFP subsection 4.1, Mandatory Responsive Requirements, regarding the submission of Attachment A, in excel, and Attachment E.
56.	Attachment E (responsive requirements) has a column for "Vendor page # of proposal." There are 9 items listed, some of which are already required to be submitted, such as Attachment F and Attachment I. However, many of the items refer to the RFP or to Attachment B (the contract). We would just like to confirm that when uploading Attachment E, the Department is only looking for that	See the posted Attachment E, Revised Responsive Requirements.

	form, signed, and not that we include the RFP or the Special Contract Conditions pages as add-ons within the same upload. We are asking because of the "vendor page # of proposal" column. We would sign and confirm that we've read and will adhere to everything, but if we don't re-attach certain items, there would be no page # to reference.	
57.	The aforementioned RFP includes an anticipated contract start date of December 17, 2019. However, as of July 8th, 2019, DMS entered into a renewal of Contract No. DMS-13/14-018A with a renewal term of July 10, 2019 until July 9, 2020. Is the aforementioned RFP, and the resulting contract awards, intended to override the exciting renewal terms effective December 17, 2019?	No. The Department intends to keep the active contracts in place.

FAILURE TO FILE A PROTEST WITHIN THE TIME PRESCRIBED IN SECTION 120.57(3), FLORIDA STATUTES, OR FAILURE TO POST THE BOND OR OTHER SECURITY REQUIRED BY LAW WITHIN THE TIME ALLOWED FOR FILING A BOND SHALL CONSTITUTE A WAIVER OF PROCEEDINGS UNDER CHAPTER 120, FLORIDA STATUTES.

Any protest must be timely filed with the Department of Management Services' Agency Clerk. Protests may be filed by courier, hand delivery, or U.S. mail at Department of Management Services, Office of the General Counsel, Attention: Agency Clerk, 4050 Esplanade Way, Suite 160, Tallahassee, FL 32399-0950. Protests may also be filed by fax at 850-922-6312 or by email at agencyclerk@dms.myflorida.com. It is the filing party's responsibility to meet all filing deadlines.

EXHIBIT 1 - STATE EMPLOYEES' GROUP HEALTH INSURANCE
PROGRAM PROGRAM ENROLLMENT
FISCAL YEAR 2018-19

Program	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Avg Enrl
Health Insurance	177,332	177,049	177,451	176,855	176,562	176,063	178,370	178,469	177,695	177,580	177,415	177,111	177,329
PPO Plan	84,586	84,568	84,949	84,744	84,631	84,444	84,523	84,570	84,267	84,333	84,329	84,226	84,514
HMO Plan	92,746	92,481	92,502	92,111	91,931	91,619	93,847	93,899	93,428	93,247	93,086	92,885	92,815
Aetna	28,206	28,131	28,171	28,046	27,988	27,895	28,577	28,606	28,464	28,400	28,343	28,292	28,260
AvMed	25,882	25,792	25,750	25,620	25,561	25,449	26,141	26,178	26,007	25,945	25,908	25,848	25,840
Capital Health	31,651	31,582	31,576	31,475	31,433	31,359	31,950	31,915	31,802	31,751	31,701	31,626	31,652
United	7,007	6,976	7,005	6,970	6,949	6,916	7,179	7,200	7,155	7,151	7,134	7,119	7,063
HSA Accounts	3,498	3,543	3,735	3,560	3,671	3,769	3,954	3,845	3,871	3,880	3,893	3,972	3,766
Life Insurance	187,357	187,102	186,996	187,952	188,060	187,785	187,841	187,928	187,329	187,156	187,639	187,461	187,551
Employees	157,654	157,419	157,314	158,186	158,362	158,161	158,246	158,297	157,615	157,556	158,101	157,939	157,904
Retirees	29,703	29,683	29,682	29,766	29,698	29,624	29,595	29,631	29,714	29,600	29,538	29,522	29,646
Life Insurance -Supplemental	75,113	74,878	74,676	74,857	74,845	74,792	81,179	81,270	81,026	80,978	81,143	81,061	77,985
Optional	40,544	40,445	40,341	40,367	40,359	40,264	44,646	44,596	44,409	44,338	44,312	44,224	42,404
Spouse	13,275	13,256	13,230	13,312	13,284	13,322	13,351	13,474	13,495	13,547	13,674	13,705	13,410
Child	21,294	21,177	21,105	21,178	21,202	21,206	23,182	23,200	23,122	23,093	23,157	23,132	22,171
Flexible Spending Plans [1]	21,091	21,150	21,162	20,963	20,885	20,811	22,695	22,609	22,576	22,599	22,548	22,473	21,797
Medical	18,782	18,821	18,811	18,638	18,555	18,480	20,244	20,161	20,129	20,138	20,084	20,017	19,405
Limited Purpose Medical	116	122	127	125	127	124	128	127	127	130	132	127	126
Dependent Care	2,193	2,207	2,224	2,200	2,203	2,207	2,323	2,321	2,320	2,331	2,332	2,329	2,266
Disability	21,450	21,369	21,338	21,372	21,438	21,472	21,461	21,373	21,373	21,318	21,300	21,273	21,377
Supplemental Insurance Plans	219,911	219,191	218,716	219,056	219,079	218,316	228,940	228,931	227,738	227,612	228,167	227,814	223,623
AFLAC	9,934	9,894	9,830	9,728	9,677	9,610	9,799	9,904	9,877	9,837	9,795	9,745	9,803
Humana Dental (Select 15/Schedule B)	17,308	17,257	17,246	17,333	17,371	17,341	16,970	17,039	16,998	17,053	17,202	17,226	17,195
Ameritas Dental	19,565	19,505	19,463	19,549	19,545	19,501	21,690	21,697	21,611	21,651	21,701	21,656	20,595
Assurant/Denticare	9,655	9,616	9,586	9,611	9,611	9,567	9,292	9,277	9,223	9,214	9,239	9,237	9,427
Cigna Dental	16,544	16,506	16,460	16,453	16,446	16,377	15,428	15,409	15,317	15,309	15,413	15,430	15,924
CIGNA Healthcare	4,760	4,722	4,680	4,625	4,595	4,573	4,629	4,608	4,552	4,519	4,500	4,460	4,602
Colonial	25,503	25,347	25,184	25,056	24,994	24,907	26,180	26,061	25,847	25,760	25,696	25,615	25,513
Humana Dental (Network Plus/Preferred Plus)	0	0	0	0	0	0	0	0	0	0	0	0	0
Humana Vision	76,616	76,404	76,325	76,609	76,660	76,391	79,401	79,441	79,079	79,098	79,401	79,344	77,897
New Era (f.k.a Phila Amer Life)	1,951	1,940	1,924	1,891	1,879	1,866	1,917	1,897	1,877	1,880	1,879	1,859	1,897
United Dental	0	0	0	0	0	0	0	0	0	0	0	0	0
MetLife	38,075	38,000	38,018	38,201	38,301	38,183	43,634	43,598	43,357	43,291	43,341	43,242	40,770
Total All Programs excl HSA	702,254	700,739	700,339	701,055	700,869	699,239	720,486	720,580	717,737	717,243	718,212	717,193	709,662

Note:
1) Unduplicated number of enrollees in both medical & dependent care flexible spending plans.

Source: NGA Vendor Count Report/Monthly Enrollmnet Files

Bureau of Financial & Fiscal Management

Exhibit C

The State of Florida

Department of Management Services

Request for Proposals (RFP)

Benefits Consulting, Actuarial, and Claims Auditing Services

RFP No: 19-80111502-A

Jessalyn Marks, Procurement Officer

Department of Management Services

4050 Esplanade Way, Suite 360G

Tallahassee, Florida 32399-0950

(850) 487-3977

Jesse.Marks@dms.myflorida.com

Failure to file a protest within the time prescribed in section 120.57(3), Florida Statutes, or failure to post the bond or other security required by law within the time allowed for filing a bond shall constitute a waiver of proceedings under chapter 120, Florida Statutes. Any protest concerning this agency decision must be timely filed with the Agency Clerk. Protests may be filed by courier, hand delivery, or U.S. mail at Department of Management Services, Office of the General Counsel, Attention: Agency Clerk, 4050 Esplanade Way, Suite 160, Tallahassee, FL 32399-0950. Protests may also be filed by fax at 850-922-6312 or by email at agencyclerk@dms.myflorida.com It is the filing party's responsibility to meet all filing deadlines.

The Procurement Officer should be copied on such filings.

TABLE OF CONTENTS

Timeline of Events

The table below contains the timeline of events for this solicitation. It is the responsibility of the Respondent to check for any changes. The dates and times within the Timeline of Events may be subject to change. All changes to the Timeline of Events will occur through an addendum to the solicitation and will be noticed on the Vendor Bid System (VBS).

Respondents shall not rely on the MyFloridaMarketPlace (MFMP) Sourcing time clock. It is not the official submission date and time deadline. The official solicitation closing time and deadlines are reflected in the Timeline of Events listed below.

Timeline of Events	Event Time (Eastern Time)	Event Date
Solicitation posted on the VBS and in MFMP Sourcing		7/30/2019
Deadline to submit questions in MFMP Sourcing	10:00 AM	8/12/2019
Department's anticipated posting of answers on the VBS		8/27/2019
Deadline to submit proposal and all required documents in MFMP Sourcing	10:00 AM	9/10/2019
Public Opening Meeting location: 4050 Esplanade Way, Room 101, Tallahassee, FL 32399-0950	10:30 AM	9/10/2019
Formal evaluations conducted		9/242019- 10/31/2019
Public Meeting for Evaluators to confirm technical scores Meeting location: 4050 Esplanade Way, Room 101, Tallahassee, FL 32399-0950	10:00 AM	11/12/2019
Anticipated date to post Notice of Intent to Award		11/19/2019
Anticipated Contract start date		12/17/2019

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1 INTRODUCTION

1.1 Objective

The State of Florida Department of Management Services' Division of State Purchasing (Department) is issuing this Request for Proposals (RFP) to establish a state term contract for Benefits Consulting, Actuarial, and Claims Auditing Services for statewide use by all Customers. During the 2019 Legislative Session, House Bill 1113 amended section 287.056, Florida Statutes (F.S.), to include the requirement that the Department enter into and maintain one or more state term contracts with benefits consulting companies. The Department is issuing this RFP in furtherance of this requirement set forth in subsection 287.056(3), F.S. (2019). The Department intends to make multiple awards per service category. There are three Service Categories within this RFP: 1) Benefits Consulting Services; 2) Actuarial Services; and 3) Claims Auditing Services.

1.2 Background Information

The solicitation will be administered using the Vendor Bid System (VBS) and MyFloridaMarketPlace (MFMP) Sourcing. The estimated annual spend for these services is $2,000,000.00. The estimated spend is for informational purposes only and should not be construed as representing actual, guaranteed, or minimum spend under a new Contract. Customers for this Contract include state agencies and eligible users.

1.3 Term

The initial term of the Contract resulting from this solicitation will be for five (5) years. Upon written agreement, the Contract may be renewed in whole or in part, in accordance with subsection 287.057(13), F.S. Any renewal is subject to the same terms and conditions set forth in the initial Contract and any written amendments signed by the parties. Any renewal is contingent upon the satisfactory performance of the Vendor and subject to the availability of funds.

1.4 Definitions

Definitions contained in section 287.012, F.S., Rule 60A-1.001, Florida Administrative Code, Attachment B - Special Contract Conditions, and the PUR 1001 form are incorporated by reference. In the event of a conflict, the definitions listed in this section supersede the incorporated definitions. All definitions apply in both their singular and plural sense.

Business day – Each day during which the State and its agencies are open for business, from 8:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday.

Commodity Code - The State of Florida numeric code for classifying commodities and contractual services which meet specific requirements, specifications, terms, and conditions herein. Florida has adopted the United Nations Standard Products and Services Code (UNSPSC) for classifying commodities and services.

Respondent – A Vendor who submits a proposal to this RFP.

State - The State of Florida.

United Nations Standard Products and Services Code (UNSPSC) – A commodity code list used by the State.

Vendor Bid System (VBS) – The State of Florida's official system for advertising competitive solicitations.

1.5 Procurement Officer

The Procurement Officer is the sole point of contact for this RFP.

Jessalyn Marks
Bureau Chief of Goods and Services, Division of State Purchasing
Florida Department of Management Services
4050 Esplanade Way, Suite 360G, Tallahassee, FL 32399-0950
Phone: (850) 487-3977
Email: Jesse.Marks@dms.myflorida.com

****ALL EMAILS TO THE PROCUREMENT OFFICER SHOULD CONTAIN THE SOLICITATION NUMBER IN THE SUBJECT LINE OF THE EMAIL****

1.6 Order of Precedence for Solicitation

In the event of a conflict, the conflict will be resolved in the following order of priority (highest to lowest):

a) Addenda to Solicitation, if issued (in reverse order of issuance)
b) Cost Proposal, Attachment A
c) Special Contract Conditions, Attachment B
d) Draft Contract, Attachment C
e) Technical Proposal and Technical Proposal Evaluation Criteria, Attachment D
f) RFP all other RFP attachments

2 SCOPE OF WORK

2.1 Purpose and Service Categories

To provide Benefits Consulting, Actuarial, and/or Claims Auditing Services pursuant to State Term Contract No. 80111502-19-1 for use by Customers. Awarded services will be provided on an as needed basis with no guaranteed or minimum spend under a new Contract. The Customer specific scope of work will be determined and agreed upon by the Customer and the selected Contractor and set forth in the Customer Contract or Purchase Order.

A Respondent may propose to offer one or more services in the following service categories set forth below:

2.1.1. Service Category 1 - Benefits Consulting – Awarded Contractor(s) will provide services related to, and/or advise Customers on, insurance and/or employee benefits. This includes providing a range of advice, assistance, guidance, counseling, and support on selecting, purchasing, and administering employee benefits.

2.1.2 Service Category 2 - Actuarial – Awarded Contractor(s) will provide actuarial services by using statistical techniques and mathematical skills to assess the probability of an event and its financial consequences.

2.1.3. Service Category 3 – Claims Auditing – Awarded Contractor(s) will audit Customer claims including analyzing payments, procedures, and guidelines of benefits. These services may include interpreting detailed paid and/or unpaid claims, eligibility for benefits, payments, and other various reports or data to determine the eligible types of services.

When creating a Customer specific scope of work, Customers are permitted to negotiate terms and conditions which supplement those contained in this Contract. Such additional terms shall be for similar or equivalent services contemplated in this Contract Scope of Work and shall not conflict with the terms and conditions established by this Contract (and any such conflicting terms shall be resolved in favor of terms most favorable to the Customer). Specific terms and conditions within a Customer's scope of work are only applicable to the Customer's Contract or Purchase Order.

2.2 Commodity Code List

UNSPSC	Commodity Description
80111502	Compensation or benefits planning
80101600	Project management
84111600	Audit services
80101500	Business and corporate management consultation services
93151600	Public finance

2.3 Job Titles and Duties

The following descriptions contain the responsibilities of personnel, provided by the Contractor, in accordance with the terms of this Contract, to provide Customers with services pursuant to the Customer's scope of work as set forth in the Customer's Contract or purchase order:

2.3.1 Principal position: A minimum of ten (10) years' experience is required for Principal positions. The functional responsibility of this position for all Service Categories may include:

- Assigning or placing staff into specific positions/projects; and
- Providing senior-level interface with the Customer and manages daily operations; and
- Prioritizing work efforts for subordinates; and
- Manage projects and/or team work efforts until completion; and
- Negotiate fees, set deadlines and prepare budgets for projects; and
- Ensuring the timely performance and completion of all contractual obligations; and
- Organizing and directing the overall performance of the Contract; and
- Possessing the authority to make binding decisions on behalf of the Contractor; and
- Formulating organizational strategy and directing major strategic initiatives; and
- Ensuring that goals and objectives are accomplished within budgetary parameters; and
- Developing and maintaining Customer relationships; and
- Assisting on large projects; and
- Allocating financial and human resources and material assets;
- Formulating and enforcing work standards; and
- Advising the Customer of the impact and significance of current or proposed federal laws and changes to the industry standards; and
- Appraising the operation to identify problems and make recommendations for improvement; and
- Participating in the design phase of tasks and ensuring successful execution of deliverables.

Customers may supplement these duties in providing services to the Customer, so long as they are similar or equivalent services that do not exceed or conflict with the services contemplated in the Department's Contract Scope of Work.

2.3.2 Senior position: A minimum of ten (10) years' experience is required for Senior positions. The functional responsibility of this position for all Service Categories may include:

- Managing the day-to-day operations; and
- Ensuring the quality and timely completion of projects; and
- Providing technical and subject matter expertise in fulfillment of a scope of work; and
- Participating as a senior team member providing high-level consulting services; and
- Planning, organizing, and executing project tasks in successful delivery of services; and
- Developing and defining strategic visions; and
- Planning, directing, controlling, scheduling, coordinating, and organizing management of tasks; and
- Providing Customer interface in fulfillment of a scope of work; and
- Possessing authority and responsibility for the execution of a scope of work; and
- Planning, organizing, and overseeing all subordinate work efforts; and
- Ensuring quality standards and work performance on all scopes of work and projects; and
- Organizing, directing, and managing support services.

Customers may supplement these duties in providing services to the Customer, so long as they are similar or equivalent services that do not exceed or conflict with the services contemplated in the Department's Contract Scope of Work.

2.3.3 Junior position: The functional responsibility of this position for all Service Categories may include:

- Applying administrative, consultative and technical expertise in fulfillment of scopes of work; and
- Planning, organizing, executing, and controlling project tasks in successful delivery of services; and
- Interfacing with client on a day-to-day basis to ensure delivery of project status; and
- Providing solutions through analysis; and
- Organizing, directing, and managing support services; and
- Assigning tasks and overseeing projects; and
- Directing project activities in fulfillment of Contract tasks/deliverables and Scopes of Work; and
- Training Customer personnel through formal classroom courses; and
- Applying a broad set of subject matter and technical expertise; and
- Directing the completion of projects within estimated timeframes and budget constraints;

Customers may supplement these duties in providing services to the Customer, so long as they are similar or equivalent services that do not exceed or conflict with the services contemplated in the Department's Contract Scope of Work.

2.4 Personnel and Project Preferences

The following descriptions contain anticipated Customer specific preferences of Contractor(s) and its personnel in providing Customer specific services pursuant to the Customer's scope of work, as set forth in the Customer's Contract or purchase order. Customers may request, in their Request for Quotes (RFQ), that the Contractor conform with the Customer specific preferences including, but not limited to, the following:

2.4.1 Service Category 1 – Benefits Consulting:

- Knowledge of government business practices, which is inclusive of State of Florida practices.
- Principal Actuaries are a Fellow of the Society of Actuaries (SOA) and have a valid SOA certification.
- All actuaries (principal, senior, and junior) are a current member of SOA or the American Academy of Actuaries.
- External peer reviews are performed of the organization and are in conformance with the peer review standards for the American Institute of Certified Public Accountants and Government Auditing Standards.

2.4.2 Service Category 2 – Actuarial:

- Knowledge of government business practices, which is inclusive of State of Florida practices.
- Principal Actuaries are a Fellow of the Society of Actuaries (SOA) and have a valid SOA certification.
- All actuaries (principal, senior, and junior) are a current member of the Society of Actuaries or the American Academy of Actuaries.

2.4.3 Service Category 3 – Claims Auditing:

- Knowledge of government business practices, which is inclusive of State of Florida practices.
- External peer reviews are performed of the organization and are in conformance with the peer review standards for the American Institute of Certified Public Accountants and Government Auditing Standards.
- Principal and Senior auditing personnel have completed at least twenty-four (24) hours of continuing professional education (CPE) within the preceding two (2) years.

2.5 Tasks and Deliverables

The following descriptions include the tasks and deliverables to be provided by the Contractor, based on the awarded Service Categories, in accordance with the terms of this Contract. Customer may supplement these duties as related to the provision of services to the Customer, so long as they are similar or equivalent services that do not exceed or conflict with the services contemplated in the Scope of Work in the Department's Contract with the Contractor.

2.5.1 Tasks

2.5.1.1 Tasks Applicable to all Service Categories. Tasks that may be permissible under this Contract include, but are not limited to:

- Provide legislative support, including, but not limited to, presentation(s) to legislative staff, and any requested analyses.
- Provide testimony as a witness in a court proceeding.
- Review proposed legislation and determine potential program impacts.
- Prepare fiscal impact notes and bill analyses.
- Consult or advise Customer by phone, letter, email, or in person.
- Conduct or assist presentations as requested.
- Perform special projects, special studies, and special evaluations as needed.
- Assist with the development and implementation of an educational and outreach strategy.
- Create and disseminate various educational materials, brochures, flyers (hard copy and online).
- Perform reviews of actuarial valuations and impact statements.
- Review content and create necessary reports.
- Verify validity of reports and calculations.

2.5.1.2 Service Category 1 – Benefits Consulting Tasks. Tasks that may be permissible for Service Category 1 include, but are not limited to:

- Assist in procurements for employee benefits.
- Assist in assessment of employee benefit plans.
- Provide consulting services as needed for plan valuation, premium modeling, benefit costing, plan design, risk assessment and fiscal impact analysis.
- Process and productivity improvement.
- Program planning and evaluations.
- Policy and regulation development assistance.
- Advisory and assistance services.
- Systems alignment and consolidation.

2.5.1.3 Service Category 2 – Actuarial Tasks. Tasks that may be permissible for Service Category 2 include, but are not limited to:

- Provide actuarial services as needed for plan valuation, premium modeling, benefit costing, plan design, risk assessment and fiscal impact analysis.
- Estimate costs of legislative changes.
- Prepare and update calculators and projection models.

2.5.1.4 Service Category 3 – Claims Auditing Tasks. Tasks that may be permissible for Service Category 3 include, but are not limited to:

- Audit Customer information processed during audit period.
- Operational assessment of administrative operations.
- Evaluate compliance with statutory, regulatory, and contractual requirements.
- Proactively search for potential fraud and abuse.

2.5.2 Deliverables

2.5.2.1 Deliverables Applicable to all Service Categories. Deliverables that are permissible under this Contract include, but are not limited to:

- Legislative support.
- Oral and written legislative analyses.
- Attend and, when requested, speak at presentations to legislative staff.

- Provide written studies/reports in draft and final form as needed
- Presentations
- Data summary

2.6 Project-Based Pricing
A project-based pricing model may be used by the Customer instead of an hourly rate model to accomplish goals and tasks that include more complex requirements. Customers who choose to use a project-based pricing model shall adhere to the requirements listed in the Request for Quote(s) Requirement Section and shall negotiate all pricing, fees and related expenses associated with the completion of each task and deliverable with the selected Contractor. Project-based pricing should be fully detailed in the Customer's scope of work.

2.7 Request for Quote(s) Requirement
Each Customer is required to include a Customer specific scope of work with a resultant Contract and/or purchase order. Before issuing a Contract and/or purchase order under this Contract, Customers shall issue a Request for Quotes (RFQs) to all Contractors awarded in the applicable Service Category (Benefits Consulting, Actuarial, and/or Claims Auditing Services) to achieve best value for the State of Florida. A Contractor may not respond to an RFQ for a Service Category for which Contractor was not awarded a Contract. Customers should consider and include the following information when requesting quotes under this Contract:

1. Statement of purpose
2. Customer specific scope of work
3. Customer project job duties
4. Customer project tasks and deliverables, completion of which is subject to Customer acceptance
5. Number of hours Contractor estimates to complete Customer project tasks and deliverable(s)
6. Customer project timeline
7. List of Contractor responsibilities
8. Necessary qualifications/certifications of the individuals/organization performing work on the Customer project. Examples include, but are not limited to: Certified Public Accountant, independence requirements of the Government Auditing Standards issued by the U.S. Government Accountability Office's Ethical Rules of the American Institute of Certified Public Accountants, etc.
9. Customer specific financial consequences for non-performance
10. Customer specific terms and conditions

2.8 Financial Consequences
Financial Consequences may be assessed for failure to timely perform or submit a report as required by the Contract. Financial consequences will be assessed on a daily basis for each individual failure until the performance or submittal is accomplished to the satisfaction of the Department and will apply to each target period beginning with the first full month or quarter of the Contract's performance and each and every month and quarter thereafter. The Customer may collect financial consequences by reducing payments to the Contractor or require the Contractor to pay via check or money order in US Dollars and made out to the Customer within thirty (30) calendar days after the required report submission date. The Department reserve the right to withhold payment, require the Contractor to pay financial consequences via check or money order in US Dollars within thirty (30) calendar days after the required report submission date, or implement other appropriate remedies, such as Contract termination or non-renewal, when the Contractor has failed to perform/comply with the provisions of the Contract.

Contract Requirement	Description	Frequency	Daily Financial Consequences for Non-Performance
Submission of complete and accurate Contract Quarterly Sales Report	Submit Quarterly Sales Report ten (10) calendar days after close of the reporting period	Each quarter	$250
Submission of complete and accurate MFMP Transaction Fee Report	Submit MFMP Transaction Fee Report fifteen (15) calendar days after close of the reporting period	Each month	$100
Untimely report(s) or deliverable(s)	Submit report(s) or deliverable(s) to Customer	Each report or deliverable	$1,500

2.9 Contractor's Responsibilities

2.9.1 Administration

The Contractor shall provide all management, administrative, clerical, and supervisory functions required for the effective and efficient performance of all scopes of work it accepts, and shall have sole responsibility for the supervision, daily direction and control, payment of salary (including withholding of income taxes and social security), and any benefits for its personnel. The Contractor is accountable to the Customer for the actions of its personnel.

Contractor's management responsibilities include, but are not limited to, the following:

1. Ensuring personnel understand the work to be performed on Customer scopes of work to which they are assigned;
2. Ensuring personnel know their management chain and adhere to Contractor policies and exhibit professional conduct to perform in the best interest of the Customer;
3. Ensuring personnel adhere to applicable laws, regulations, and Contract conditions governing Contractor performance and relationships with the Customer;
4. Regularly assessing personnel performance and providing feedback to improve overall task performance; and
5. Ensuring high quality results are achieved through task performance.

2.10 Contractor Warranty

The Contractor agrees to the following representation and warranty:

Should any defect or deficiency in any Deliverable, or the remedy of such defect or deficiency, cause incorrect data to be introduced into any Customer's database or cause data to be lost, the Contractor shall be required to correct and reconstruct, within the timeframe established by the Customer, all production, test, acceptance and training files or databases affected which are used in the provision of services, at no additional cost to the Customer.

2.11 Holidays

The Contractor shall provide Customers all services during Business Days. The following days are observed as holidays by state agencies in accordance with section 110.117, F.S.:

- New Year's Day
- Birthday of Martin Luther King, Jr., third Monday in January
- Memorial Day
- Independence Day
- Labor Day
- Veterans' Day, November 11
- Thanksgiving Day
- Friday after Thanksgiving
- Christmas Day

If any of these holidays falls on Saturday, the preceding Friday shall be observed as a holiday. If any of these holidays falls on Sunday, the following Monday shall be observed as a holiday.

Customers may have additional holiday(s) observed specifically by the Customer which will be detailed in the Customer's Contract and/or purchase order.

2.12 Routine Communications

All routine communications and reports related to the Contract shall be sent to the Department's Contract Manager. If any information listed on the Vendor Information and Ordering Instructions attachments changes during the life of the Contract, then the Contractor shall update the attachments and submit to the Department's Contract Manager. Communications relating to a specific order should be addressed to the contact person identified on the order. Communications may be by e-mail, regular mail, or telephone.

2.13 Contract Reporting

The Contractor shall report information on orders received from Customers associated with this contract. The Contractor shall submit reports in accordance with the following schedule:

Report	Period Covered	Due dates
MFMP Transaction Fee Report	Calendar month	Fifteen (15) calendar days after the end of each month
Contract Quarterly Sales Report	State's Fiscal Quarter	Ten (10) calendar days after close of the period
Diversity Report (submitted to the Customer)	State Fiscal Year	Ten (10) business days after close of the period

2.13.1 MFMP Transaction Fee Report

The Contractor is required to submit monthly Transaction Fee Reports in the Department's electronic format. Reports are due fifteen (15) calendar days after the end of the reporting period. For information on how to submit Transaction Fee Reports online, please reference the detailed fee reporting instructions and vendor training presentations available online at the Transaction Fee & Reporting section and Training for Vendors subsections under Vendors on the MFMP website. Assistance with Transaction Fee Reporting is also available from the MFMP Customer Service Desk by email at feeprocessing@myfloridamarketplace.com or telephone 866-FLA-EPRO (866-352-3776) from 8:00 a.m. to 6:00 p.m. Eastern Time.

2.13.2 Contract Quarterly Sales Reports

The Contractor shall submit a Contract quarterly sales report electronically, in the required format, to the Department's Contract Manager within ten (10) calendar days after close of each quarter. The Department reserves the right to require the Contractor to provide additional reports within thirty (30) calendar days written notice. Failure to provide the Contract quarterly sales report, or other reports requested by the Department, may result in the imposition of financial consequences or the Contractor being found in default and may result in contract termination. Initiation and submission of the Contract quarterly sales report are the responsibility of the Contractor without prompting or notification by the Department. Sales will be reviewed on a quarterly basis. If no sales are recorded in two consecutive Contract quarters, the Department may terminate the Contract.

Quarter 1 – (July-September) – due ten (10) calendar days after the close of the period.
Quarter 2 – (October-December) – due ten (10) calendar days after the close of the period.
Quarter 3 – (January-March) – due ten (10) calendar days after the close of the period.
Quarter 4 – (April-June) due ten (10) calendar days after the close of the period.

2.13.3 Diversity Report

The Contractor shall report to each Customer, spend with certified and other minority business enterprises. These reports shall include the period covered, the name, minority code and Federal Employer Identification Number of each minority business utilized during the period, commodities and services provided by the minority business enterprise, and the amount paid to each minority business on behalf of each purchasing agency ordering under the terms of this Contract.

2.13.4 Ad-hoc Report

The Department may require additional Contract information such as copies of purchase orders, or ad hoc sales reports. The Contractor shall submit these specific ad hoc requests for reports within the specified amount of time as requested by the Department.

2.14 Business Review Meetings

In order to maintain the partnership between the Department and the Contractor, each quarter the Department may request a business review meeting. The business review meeting may include, but is not limited to, the following:

- Successful completion of deliverables
- Review of the Contractor's performance
- Review of minimum required reports
- Addressing of any elevated Customer issues
- Review of continuous improvement ideas that may help lower total costs and/or improve business efficiencies.

2.15 Price Adjustments
The Contractor shall provide initial and renewal term hourly rates (pricing) as provided to Department in the Cost Proposal. The Department will not allow for price increases throughout the life of the Contract unless specified in the renewal pricing submitting by the Contractor. Negotiated prices are not-to-exceed prices and lower prices may be negotiated by the Department and/or the Customer under this Contract.

2.16 Contract Transition
Upon Contract expiration or termination, the incumbent shall ensure a seamless transfer of Contract responsibilities with any subsequent Contractor necessary to transition the services of this Contract. Contractor agrees to cooperate with the Department and a subsequently awarded contractor to coordinate the transition including, but not limited to, attending meetings and furnishing necessary information. The incumbent Contractor and subsequent Contractor assume all expenses related to the Contract transition.

2.17 Purchasing Card
The state of Florida has implemented a purchasing card program, using the Visa platform. The Contractor may receive payments via the state's Purchasing Card in the same manner as any other Visa purchases. Purchasing Card/Visa acceptance for purchase is a mandatory requirement for the Contract but is not the exclusive method of payment. If the state of Florida changes its Purchasing Card platform during the term of Contract, the Contractor shall make any necessary changes to accommodate the State of Florida's new Purchasing Card platform within thirty (30) days of notification of such change.

3 RFP STANDARD INSTRUCTIONS

3.1 Limitation on Contact with Government Personnel (Subsection 287.057(23), F.S.)
Respondents to this solicitation or persons acting on their behalf may not contact, between the release of this solicitation and the end of the seventy-two (72)-hour period following the Department posting the Notice of Intended Award, excluding Saturdays, Sundays, and State holidays,, Respondents to this solicitation or persons acting on their behalf may not contact any employee or officer of the executive or legislative branch concerning any aspect of this solicitation, except in writing to the Procurement Officer or as provided in the solicitation documents. Violation of this provision may be grounds for rejecting a response.

3.2 Minor Irregularities
Although the Department defines certain items as requirements for responding to this RFP, the Department reserves the right to waive any minor irregularity, technicality, or omission if the Department determines, in its sole discretion, that it is in the best interest of the State to do so. There is no guarantee that the Department will waive a minor irregularity, omission, or deviation, or that any Vendor with a proposal containing a minor irregularity, deviation, or omission will be considered for award of this procurement. The Department may reject any proposal not submitted in the manner specified by this solicitation.

3.3 Special Accommodations
Any person requiring a special accommodation due to a disability should contact the Department's Americans with Disabilities Act (ADA) Coordinator at (850) 922-7535 at least five (5) Business Days prior to the scheduled event. If you are hearing or speech-impaired, please contact the ADA Coordinator by using the Florida Relay Service at (800) 955-8771 (TDD). The telephone numbers are supplied for notice purposes only.

3.4 Lobbying Disclosure
The successful Respondent shall comply with applicable federal requirements for the disclosure of information regarding lobbying activities of the successful Respondent, subcontractors or any authorized agent.

3.5 Rejection of Proposals
Proposals that do not conform in all material respects to the solicitation requirements, specifications, terms, and conditions shall be rejected as non-responsive. Respondents whose proposals, references, or current status do not reflect the capability, integrity, or reliability to fully and in good faith perform the requirements of a Contract may be deemed not responsible and the Proposal rejected as non-responsive. Proposals which include a condition or exception that are not consistent with the primary goals of the solicitation may result in the Proposal being found not in conformance in all material respects of the solicitation and be rejected as non-responsive. Alternatively, and in the Department's sole discretion, the Department may disregard or reject any condition or exception included in a proposal. The Department reserves the right to determine which proposals meet the requirements of this solicitation, and which Respondents are responsive and responsible.

3.6 Right to Reject
The Department reserves the right to accept or reject all proposals, or separable portions thereof, and to waive any minor irregularity, technicality, or omission if the Department determines that doing so shall serve the Department's best interests. The Department may reject any proposal not submitted in the manner specified by the solicitation documents.

3.7 Redacted Submissions
The following section supplements section 19 of the PUR 1001. If Respondent considers any portion of the documents, data, or records submitted in response to this solicitation to be confidential, proprietary, trade secret, or otherwise not subject to disclosure pursuant to Chapter 119, F.S., the Florida Constitution or other authority, Respondent must mark the document as "Confidential" and simultaneously provide the Department with a separate redacted copy of its proposal and briefly describe in writing the grounds for claiming exemption from the public records law, including the specific statutory citation for such exemption. This redacted copy shall contain the Department's solicitation name, number, and the Respondent's name on the cover, and shall be clearly titled "Redacted Copy." The Redacted Copy should only redact those portions of material that the Respondent claims is confidential, proprietary, trade secret or otherwise not subject to disclosure.

In the event of a request for public records pursuant to Chapter 119, F.S., the Florida Constitution or other authority, to which documents that are marked as confidential are responsive, the Department will provide the Redacted Copy to the requestor. If a requestor asserts a right to the Confidential Information, the Department will notify the Respondent such an assertion has been made. It is the Respondent's responsibility to assert that the information in question is exempt from disclosure under Chapter 119, F.S., or other applicable law. If the Department becomes subject to a demand for discovery or disclosure of the Confidential Information of the Respondent in a legal proceeding, the Department shall give the Respondent prompt notice of the demand prior to releasing the information (unless otherwise prohibited by applicable law). The Respondent shall be responsible for defending its determination that the redacted portions of its proposal are confidential, proprietary, trade secret, or otherwise not subject to disclosure.

By submitting a proposal, the Respondent agrees to protect, defend, and indemnify the Department for all claims arising from or relating to the Respondent's determination that the

redacted portions of its proposal are confidential, proprietary, trade secret, or otherwise not subject to disclosure. If Respondent fails to submit a redacted copy of information it claims is confidential, the Department is authorized to produce the entire documents, data, or records submitted to the Department in answer to a public records request for these records.

3.8 Additional Information

By submitting a proposal, Respondent certifies that it agrees to and satisfies all criteria specified in the RFP. The Department may request, and Respondent shall provide, clarifying or supporting information or documentation. Failure to provide clarifying or supporting information or documentation as requested may result in the rejection of the proposal.

3.9 Commitment to Diversity in Government Contracting

The State of Florida is committed to supporting its diverse business industry and population through ensuring participation by woman-, veteran-, and minority-owned small businesses in the economic life of the state. The State of Florida Mentor Protégé Program connects certified business enterprises with private corporations for business development mentoring. The Department strongly encourages firms doing business with the State of Florida to consider participating in this program.

The Department supports diversity in its Procurement Program, and requests that all subcontracting opportunities afforded by this solicitation enthusiastically embrace diversity. The award of subcontracts should reflect the vast array of citizens in the State of Florida. The Respondent may contact the Office of Supplier Diversity at (850) 487-0915 or osdinfo@dms.myflorida.com for more information on certified business enterprises that may be considered for subcontracting opportunities and for more information on the Mentor Protégé Program.

3.10 Identical Tie

If the Department receives two identical Proposals, the Department will select a Respondent in accordance with Florida law and in the best interest of the state.

4 RFP SPECIFIC REQUIREMENTS

4.1 Mandatory Responsive Requirements

The Department will not evaluate Proposals that do not meet the minimum mandatory, responsive requirements listed below. A Proposal will be deemed non-responsive if it fails to contain the documentation required as set forth below in 4.1.1 through 4.1.2.

4.1.1 Attachment A – Cost Proposal

The Respondent must submit the provided Attachment A – Cost Proposal in an excel file and include pricing for each Service Category(ies) for which the Respondent is submitting a Proposal. For the Respondent to be considered for an award in a Service Category, the Respondent is required to submit pricing for all job titles (principal, senior, and junior) for both the initial term and renewal term. The Department will not consider or evaluate a proposal for a Service Category that fails to provide pricing for all job titles for both the initial term and the renewal term.

4.1.2 Attachment E – Responsive Requirements

The Respondent must submit a completed Attachment E – Responsive Requirements document.

4.2 Post Award Requirements

The following documents are required to be provided to the Department prior to Contract execution:

4.2.1 Registration with the Florida Department of State

If awarded a Contract, the Respondent shall provide the Department with a PDF file of its current and active registration with the Department of State prior to contract execution. Pursuant to section 607.1501, F.S., out-of-state corporations, as may be required, must obtain a current and active Florida Certificate of Authority. Website: www.sunbiz.org.

4.2.2 Florida Substitute Form W-9

If awarded a Contract, the Respondent shall register and complete an electronic Florida Substitute Form W-9 prior to execution of a Contract. The Internal Revenue Service (IRS) receives and validates the information vendors provide on the Florida Substitute Form W-9. For instructions on how to complete the Florida Substitute Form W-9, please visit: https://flvendor.myfloridacfo.com/.

5 RESPONDING TO THE RFP

5.1 Question Submission

The Department invites interested and registered Vendors to submit written questions regarding the solicitation through the MFMP Sourcing. Vendors who have 'Joined' the MFMP Sourcing event may submit questions using the MFMP Sourcing 'Messages' tab (referred to as the "Q&A Board" in PUR 1001). Questions may be submitted in MFMP Sourcing during the Preview Status until the Question Submission Deadline listed in the Timeline of Events.

The following quoted text replaces Paragraph 5 of PUR 1001, which is incorporated by reference in section 6.1, General Instructions:

"Questions must be submitted via the Q&A Board within MFMP Sourcing and must be RECEIVED NO LATER THAN the time and date reflected on the Timeline of Events. Questions shall be answered in accordance with the Timeline of Events. All answers to properly submitted questions will be issued by an addendum and published in a manner that all proposers will be able to view. Proposers shall not contact any other employee of the Department or the State for information with respect to this solicitation. Each respondent is responsible for monitoring the Vendor Bid System for new or changing information. The Department shall not be bound by any verbal information or by any written information that is not contained in the solicitation documents or formally noticed and issued by the Department's contracting personnel. Questions to the Procurement Officer or to any Department personnel shall not constitute formal protest of the specifications or of the solicitation, a process addressed in paragraph 20 of the PUR 1001."

Respondents are strongly encouraged to raise any questions or concerns regarding this RFP, including the proposed Contract terms and conditions, during the open question period.

5.2 Addenda to the RFP

The Department reserves the right to modify this solicitation by addenda. Addenda may modify any aspect of this solicitation. Any addenda issued will be posted on the VBS. It is the Respondent's responsibility to check for any changes to a solicitation prior to submitting a proposal.

5.3 Public Opening

Proposals will be opened on the date and at the location indicated in the Timeline of Events. Respondents are not required to attend. The Department generally does not announce prices or release other materials at this public meeting, pursuant to paragraph 119.071(1)(b), F.S.

5.4 Technical Evaluation and Evaluator's Public Meeting

The Evaluators will independently review and score the responsive and responsible technical proposals using the evaluation criteria described in Attachment D - Technical Proposal and Technical Proposal Evaluation Criteria. The Department will then hold a public meeting in which the evaluators will confirm their technical scores in accordance with the Timeline of Events.

5.5 Basis of Award

Contract(s) will be awarded to the responsive and responsible Vendor(s) per Service Category that is determined to be the most advantageous to the state with the highest total final score. The Department will issue an award per Service Category (i.e. 1) Benefits Consulting Services, 2) Actuarial Services, and 3) Claims Auditing Services) to the vendor with the highest total final score, which will be calculated by the Procurement Officer by combining the average of the evaluator technical scores and the cost proposal score. A Contract for a Service Category will be awarded to the responsive and responsible Respondent(s) whose proposal is determined in writing to be the most advantageous to the State, taking into consideration the price and other criteria set forth in this RFP. The Department will consider the total cost for each year of the Contract, including initial and renewal years as submitted by the Respondent. The Department reserves the right to make multiple awards per Service Category to Respondents whose total final score is within 20% of the highest total final score for that Service Category. The methodology for scoring each Service Category is outlined below:

Proposal	Available Points
A. Technical Proposal (Attachment D)	**130**
B. Cost Proposal (Attachment A)	**70**
Total Available Points for a Service Category (A + B)	**200**

A Respondent may receive awards for multiple proposed Service Categories in accordance with the terms of the RFP. The Department reserves the right to award multiple Contracts, for all or part of the work contemplated by this solicitation. The Department reserves the right to accept or reject any and all offers, and to waive any minor irregularity, technicality, or omission if the Department determines that doing so will serve the best interest of the state. However, the Department reserves the right to make no award in one or all Service Categories as determined to be in the best interest of the State.

5.5.1 Technical Proposal - 130 Available Points for a Service Category

The Respondent shall be awarded up to 130 points for a Service Category based on its submitted Technical Proposal in accordance with the evaluation criteria outlined in Attachment D - Technical Proposal and Technical Proposal Evaluation Criteria.

5.5.2 Cost Proposal - 70 Available Points for a Service Category

The Respondent is required to submit in its Cost Proposal not-to-exceed hourly rates for all three job titles (principal, senior, junior) for both the Initial Term and Renewal Term for a Service Category for which the Respondent is seeking to offer services. The Department will not consider or evaluate a proposal for any Service Category that fails to provide

pricing for all three job titles for both the Initial Term and Renewal Term. The Respondent shall be awarded up to 70 points for a Service Category for its submitted Cost Proposal. The Respondent shall receive points based on the following methodology:

5.5.2.1 Service Category 1: Benefits Consulting Services

The Respondent's Service Category 1 Cost Proposal Score shall be calculated by the Department using the following formula and used for scoring purposes only:

(Sum of Initial Term Hourly Rates for all three Job Titles x 0.6) +
(Sum of Renewal Term Hourly Rates for all three Job Titles x 0.4) =
Calculated Hourly Rate for Service Category 1

The Respondent with the lowest Calculated Hourly Rate for Service Category 1 shall receive 70 points. Other Respondents shall receive points based on the following formula:

$(X \div N) \times 70 = Z$

Where:
X = lowest Calculated Hourly Rate for Service Category 1 of all responses
N = Respondent's Calculated Hourly Rate for Service Category 1
Z = points awarded

5.5.2.2 Service Category 2: Actuarial Services

The Respondent's Service Category 2 Cost Proposal Score shall be calculated by the Department using the following formula and used for scoring purposes only:

(Sum of Initial Term Hourly Rates for all three Job Titles x 0.6) +
(Sum of Renewal Term Hourly Rates for all three Job Titles x 0.4) =
Calculated Hourly Rate for Service Category 2

The Respondent with the lowest Calculated Hourly Rate for Service Category 2 shall receive 70 points. Other Respondents shall receive points based on the following formula:

$(X \div N) \times 70 = Z$

Where:
X = lowest Calculated Hourly Rate for Service Category 2 of all responses
N = Respondent's Calculated Hourly Rate for Service Category 2
Z = points awarded

5.5.2.3 Service Category 3: Claims Auditing Services

The Respondent's Service Category 3 Cost Proposal Score shall be calculated by the Department using the following formula and used for scoring purposes only:

(Sum of Initial Term Hourly Rates for all three Job Titles x 0.6) +
(Sum of Renewal Term Hourly Rates for all three Job Titles x 0.4) =
Calculated Hourly Rate for Service Category 3

The Respondent with the lowest Calculated Hourly Rate for Service Category 3 shall receive 70 points. Other Respondents shall receive points based on the following formula:

$(X \div N) \times 70 = Z$

Where:
X = lowest Calculated Hourly Rate for Service Category 3 of all responses
N = Respondent's Calculated Hourly Rate for Service Category 3
Z = points awarded

5.6 Electronic Posting of Notice of Intended Award

The Department shall electronically post a Notice of Intended Award on the VBS for review by interested parties at the time and location specified in the Timeline of Events. The Notice of Intended Award shall remain posted for a period of seventy-two (72) hours, not including weekends or State observed holidays. If the Notice of Intended Award is delayed, in lieu of posting the Notice of Intended Award, the Department may post a notice of delay and a revised date for posting the Notice of Intended Award.

5.7 Firm Response

The Department intends to award a Contract within sixty (60) days after the date of the proposal opening, during which period proposals shall remain firm and shall not be withdrawn. If an award is not made within sixty (60) days, all proposals shall remain firm until either the Department awards the Contract(s) or the Department receives from the Respondent written notice that the proposal is withdrawn. Proposals that express a shorter duration may, in the Department's sole discretion, be accepted or rejected.

5.8 Modification or Withdrawal of Proposal

A Respondent is responsible for the content and accuracy of its proposal. A Respondent may modify or withdraw its proposal at any time prior to the proposal due date in accordance with the Timeline of Events.

5.9 Cost of Response Preparation and Independent Preparation

The costs related to the development and submission of a response to this RFP are the full responsibility of the Respondent and are not chargeable to the Department. A Respondent shall not, directly or indirectly, collude, consult, communicate or agree with any other Vendor or Respondent as to any matter related to the proposal each is submitting. Additionally, a Respondent shall not induce any other Respondent to modify, withdraw, submit or not submit a proposal.

5.10 Contract Formation

The Department may issue a Notice of Intended Award, to successful Respondent(s). However, no Contract shall be formed between a Respondent and the Department until the Department signs the Contract. The Department shall not be liable for any work performed before the Contract is effective.

The Department intends to enter into a Contract(s) with Respondent(s) pursuant to the Basis for Award section of this solicitation. No additional documents submitted by a Respondent shall be incorporated in the Contract unless it is specifically identified, incorporated by reference, and

approved by the Department. If any additional documents are submitted by the Respondent, the additional documents will not be considered for the Basis for Award.

6 GENERAL INSTRUCTIONS

6.1 General Instructions

PUR 1001, the General Instructions to Respondents, as modified by this RFP, is incorporated by reference and provided via the link below:
http://www.dms.myflorida.com/content/download/2934/11780/1001.pdf

The following sections of the PUR 1001 are inapplicable:
Section 3. Electronic Submission of Proposals
Proposals shall be submitted in accordance with Section 6.2 of this solicitation.

Section 5. Questions
Questions shall be submitted in accordance with Section 5.2 of this solicitation.

The following section of the PUR 1001 (General Instructions) is modified as follows:

Section 9. Respondent's Representation and Authorization.
In submitting a response, each respondent understands, represents, and acknowledges the following.

- *The Respondent is not currently under suspension or debarment by the State or any other governmental authority.*
- *To the best of the knowledge of the person signing the response, the Respondent, its affiliates, subsidiaries, directors, officers, and employees are not currently under investigation by any governmental authority and have not in the last 10 years been convicted or found liable for any act prohibited by law in any jurisdiction, involving conspiracy or collusion with respect to bidding on any public contract.*
- *Respondent currently has no delinquent obligations to the State, including a claim by the State for liquidated damages under any other contract.*
- *The submission is made in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary or other noncompetitive response.*
- *The prices and amounts have been arrived at independently and without consultation, communication, or agreement with any other respondent or potential respondent; neither the prices nor amounts, actual or approximate, have been disclosed to any respondent or potential respondent, and they will not be disclosed before the solicitation opening.*
- *The Respondent has fully informed the Department in writing of all convictions of the firm, its affiliates (as defined in section 287.133(1)(a) of the Florida Statutes), and all directors, officers, and employees of the firm and its affiliates for violation of state or federal antitrust laws with respect to a public contract for violation of any state or federal law involving fraud, bribery, collusion, conspiracy or material misrepresentation with respect to a public contract. This includes disclosure of the names of current employees who were convicted of contract crimes while in the employ of another company.*
- *Neither the Respondent nor any person associated with it in the capacity of owner, partner, director, officer, principal, investigator, project director, manager, auditor, or position involving the administration of federal funds:*

- *Has within the preceding three years been convicted of or had a civil judgment rendered against them or is presently indicted for or otherwise criminally or civilly charged for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a federal, state, or local government transaction or public contract; violation of federal or state antitrust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; or*
- *Has within a three-year period preceding this certification had one or more federal, state, or local government contracts terminated for cause or reason of default that would impair the Respondent's ability to deliver the commodities or contractual services of the resultant contract.*

- *The product offered by the Respondent will conform to the specifications without exception.*
- *The Respondent has read and understands the Contract terms and conditions, and the submission is made in conformance with those terms and conditions.*
- *If an award is made to the respondent, the respondent agrees that it intends to be legally bound to the Contract that is formed with the State.*
- *The Respondent has made a diligent inquiry of its employees and agents responsible for preparing, approving, or submitting the response, and has been advised by each of them that he or she has not participated in any communication, consultation, discussion, agreement, collusion, act or other conduct inconsistent with any of the statements and representations made in the response.*
- *The Respondent shall indemnify, defend, and hold harmless the Department and its employees against any cost, damage, or expense which may be incurred or be caused by any error in the respondent's preparation of its proposal.*
- *All information provided by, and representations made by, the Respondent are material and important and will be relied upon by the Department in awarding the Contract. Any misstatement shall be treated as fraudulent concealment from the Department of the true facts relating to submission of the proposal. A misrepresentation shall be punishable under law, including, but not limited to, Chapter 817 of the Florida Statutes.*

6.2 How to Submit a Proposal in MyFloridaMarketPlace

6.2.1 MFMP Registration

In order to submit questions regarding this procurement, and to submit a response to the solicitation, a Respondent must be a registered Vendor in the MFMP Vendor Information Portal (VIP). Registered Vendors must log in to the MFMP Sourcing using their MFMP VIP username and password to ensure that their contact information is correct and that they have registered with the matching commodity code of the MFMP Sourcing event. To participate in the procurement, a Vendor must also indicate its intent to participate in electronic solicitations in MFMP Sourcing on the 'Solicitations' page of their MFMP VIP account.

<u>If you are not currently registered with MFMP VIP, you must</u>:

a) Create an account through the MFMP VIP.
b) Within MFMP VIP, indicate on the 'Solicitations' page that you wish to participate in electronic solicitations.
c) Within MFMP VIP, in the Commodity Selections section, ensure that you have selected the matching commodity codes used in this procurement. Vendors will not receive notifications for procurements with commodity codes that they have not selected in their MFMP VIP account.

Please note: VBS and MFMP Sourcing may provide automated notifications to the Vendor community, as a courtesy, based on commodity codes that are tied to a Vendor's registration in the MFMP VIP. Vendors with a commodity code that matches the commodity code of the MFMP Sourcing event will be able to 'Join' the MFMP Sourcing event. If a Vendor does not have a matching commodity code, VBS and MFMP Sourcing will not provide a courtesy notification and the Vendor will not be able to 'Join' the MFMP Sourcing event. Vendors have the ability to access and update their registration in VIP by adding commodity codes to their business profile. Changes made in MFMP VIP, including new registrations, may take forty-eight (48) hours to take effect.

The MFMP VIP can be accessed via this link: https://vendor.myfloridamarketplace.com/

The Department strongly recommends setting your MS Internet Explorer browser to compatibility mode while using MFMP applications. For more information regarding recommended internet browser settings, please click here.

ALL VENDORS MUST 'JOIN' THE MFMP SOURCING EVENT BY THE TIME AND DATE LISTED IN THE TIMELINE OF EVENTS IN ORDER TO PARTICIPATE IN THIS SOLICITATION.

In order to 'Join' the MFMP Sourcing event, Vendors must:

a) have a current MFMP Vendor registration within the MFMP VIP; and
b) select 'Yes' to participate in electronic sourcing events in MFMP Sourcing on the 'Solicitations' page of their MFMP VIP account.

MFMP Sourcing may be accessed using the following link: https://sourcing.myfloridamarketplace.com

6.2.2 MFMP Sourcing Phases: A solicitation formally begins when the Department posts a Notice on VBS. The Department will also publish the procurement in MFMP Sourcing. Do not rely on MFMP Sourcing for notices of procurements or agency decisions. VBS is the centralized procurement website designated by the Department for electronic posting of competitive procurements, addenda, agency decisions, intended decisions, including, but not limited to, intended contract awards. MFMP Sourcing is the application for submitting formal questions in response to the solicitation.

The following are MFMP Sourcing phases:

Preview Status

When this solicitation is published as a 'Public Event' in MFMP Sourcing, it will initially exist in a 'Preview' status. During the 'Preview' status, Vendors without a matching commodity code can only preview the MFMP Sourcing event. Vendors with a matching commodity code can 'Join' the event, view and download solicitation documents, and accept the 'Respondent's Agreement.'

In accordance with the time stated on the Timeline of Events, Vendors may submit questions to the Procurement Officer in the 'Messages' tab of the MFMP Sourcing event, during the Preview status, after they have joined the event. The solicitation will remain in 'Preview' status until the 'Open' status begins.

Open Status
The solicitation will be in 'Open' status on the date listed on the Timeline of Events. When a solicitation is in 'Open' status, all registered Vendors with a matching commodity code, who 'Join' the MFMP Sourcing event and accept the 'Respondents Agreement' may submit Proposals until the Proposals Due date listed in the solicitation's Timeline of Events section.

The solicitation remains in 'Open' status until the Proposals Due date and time listed in the solicitation's Timeline of Events section.

Pending Selection Status
After the response due date in the Timeline of Events, the solicitation will enter 'Pending Selection' status. During this phase of the solicitation, the 'Pending Selection' tab will appear in MFMP Sourcing.

Completed Status
If the tab in MFMP Sourcing indicates 'Completed,' either a Notice of Intent to Award or a Notice to Reject All Proposals has been posted on VBS. However, do not rely on MFMP Sourcing for this information. The VBS is the centralized procurement website for the posting of agency decisions.

6.2.3 MFMP Training

MFMP University offers Vendor training materials on the Department's website at: https://www.dms.myflorida.com/business_operations/state_purchasing/myfloridamarketplace/mfmp_vendors/training_for_vendors.

For vendors responding to this solicitation, it is highly recommended that vendors review the training provided via this link for Responding to Electronic Solicitations: https://www.dms.myflorida.com/content/download/140134/903704/Responding_to_Electronic_Solicitations.pdf

Please visit MFMP University to access online trainings on a variety of topics, including Vendor Registration and Selecting Commodity Codes.

6.2.4 MFMP Assistance

If you need assistance with using MFMP, please contact the MFMP Customer Service Desk at VendorHelp@myfloridamarketplace.com or (866) 352-3776.

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RFP ATTACHMENTS

Attachment A - Cost Proposal (must be submitted prior to RFP opening)
Attachment B – Special Contract Conditions
Attachment C – Draft Contract
Attachment D – Technical Proposal and Technical Proposal Evaluation Criteria (vendor response must be submitted prior to RFP opening)
Attachment E – Responsive Requirements (must be submitted prior to RFP opening)
Attachment F – Vendor Information
Attachment G – No Offshoring
Attachment H – Certification of Drug-Free Workplace
Attachment I – Subcontracting

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Exhibit D
Benefits Consulting, Actuarial, and Claims Auditing Services

Respondent Name	Mercer Health & Benefits, LLC.

INSTRUCTIONS
The Respondent may respond to one or more service category.
The Respondent is not required to respond to all service categories.
A Respondent must submit a price in all yellow highlighted cells for the Service Category for which the Respondent is proposing services.
Provide pricing for all job titles within each service category for which the Respondent is proposing to offer.
For Respondent to be considered for an award in a Service Category, the Respondent is required to submit pricing for all job titles within the Service Category they are proposing to offer services for both the Initial Term and Renewal Term. The Department will not consider or evaluate a proposal for any Service Category that fails to provide pricing for all job titles in a Service Category for both the Initial Term and Renewal Term.
Please refer to the Job Titles and Duties section of the RFP for definitions of job titles.
The Attachment A, Cost Proposal, establishes pricing for services offered for the term of the contract and any renewals. The Respondent shall not exceed this pricing when providing services under any resultant contract.
Provide pricing in dollar amounts; amounts cannot include fractions of cents (e.g. $0.005).
The price shall be based on meeting or exceeding the material specifications in the Statement of Work.
Proposed costs are ceiling rates inclusive of any and all costs associated with providing services.

Service Category 1: Benefits Consulting Services		
JOB TITLE	INITIAL TERM HOURLY RATE	RENEWAL TERM HOURLY RATE
Principal Benefits Consultant	$699.00	$810.33
Senior Benefits Consultant	$499.00	$578.48
Junior Benefits Consultant	$299.00	$346.62

Service Category 2: Actuarial Services		
JOB TITLE	INITIAL TERM HOURLY RATE	RENEWAL TERM HOURLY RATE
Principal Actuary	$768.90	$891.37
Senior Actuary	$548.90	$636.33
Junior Actuary	$299.00	$346.62

Service Category 3: Claims Auditing Services		
JOB TITLE	INITIAL TERM HOURLY RATE	RENEWAL TERM HOURLY RATE
Principal Claims Auditor	$559.20	$648.27
Senior Claims Auditor	$399.20	$462.78
Junior Claims Auditor	$299.00	$346.62

Exhibit E

TECHNICAL PROPOSAL (ATTACHMENT D)
SERVICE CATEGORY 1 – BENEFITS CONSULTING

REQUEST FOR PROPOSALS - NO. 19-801111502

As required by the RFP, Mercer's Technical Proposal contains two parts and are submitted separately for each Service Category:

- **Experience:** focuses on Mercer's capabilities in the Service Category and the qualifications of the specific team members who will deliver the services to the Customer.
- **Proposed Solution:** describes our processes and approach for delivering the requested services in the Service Category.

PART 1: EXPERIENCE

Mercer has been providing health and benefits services for more than 80 years. Our US Health business comprises nearly 2,500 employees, and serves almost 4,000 clients, including state governments. With one of the largest groups of seasoned experts with knowledge and experience spanning every aspect of healthcare, Mercer is well-positioned to provide all of the services requested in each of the three Service Categories: Benefits Consulting, Actuarial and Claims Auditing. A general description of our firm's capabilities in addition to those in the Benefits Consulting Service Category is provided below, along with information about the core team members who will provide the services to the Customer (as reflected in the RFP we have used the general term "Customer" throughout our proposal to reflect all state agencies and eligible users for this Contract).

Mercer believes there are three (3) primary reasons that we are uniquely capable of assisting in achieving your goals and objectives:

- We know your industry/state governments, your program, vendors, the market, and you/Customer
- We Bring Unequaled Expertise, Capabilities, and Approach
- No Transition Issues or Risks, and a History of Proven Value and Commitment

➢ 1. We know your industry/state governments, your program, vendors, market, and you/Customer

Knowing Your Plans, Vendors and History, Uniquely Qualifies Us to Meet Your Needs

Over the years, Mercer has worked with you to ensure delivery of effective strategies and solutions. We have helped you define your principles, key issues and strategic priorities. We have shown we can work quickly with you to identify, craft, and validate new solutions to meet your current and future needs. We pride ourselves on delivering high-quality advice; services and solutions that have helped the State of Florida facilitate discussions and produce results.

Your Mercer team knows you and your history, allowing us to effectively revise or leverage prior work with minimal cost and transition time. In the past few years, we have provided support to the State of Florida including the following initiatives:

- Numerous actuarial modeling projects, including pricing, review, analysis of alternative designs and contributions, and impact to overall budget
- Medical plan analysis and procurement consulting
- Pharmacy plan analysis, renewal negotiation guidance, and PBM procurement consulting
- Benchmarking (our survey resources are well known and considered the "gold standard" in the industry
- Pharmacy performance and operational audits
- Healthcare reform actuarial modeling
- HMO plan referral pattern analysis (in depth data analytics project) and actuarial modeling
- Compliance support (Mental Health Parity review)
- Persona cluster analysis
- MAPD consulting
- Legislative support

As we look ahead, Mercer is uniquely positioned to help you both ***cost-effectively*** apply those strategies and tactics previously identified as valid and ***quickly take a fresh look*** for building new ideas that enhance your benefit and total rewards programs.

➢ 2. We Bring Unequaled Expertise, Capabilities, and Approach

OVERVIEW: BENEFITS CONSULTING CAPABILITIES

We offer a complete set of advisory and transactional services for every segment of the benefits marketplace. Mercer can address all of your unique needs and provide services in any state, especially throughout the entire state of Florida.

Core Services

As an example of some of the items we can assist with our typical core benefits consulting services are summarized in the table below (please note that our capabilities are much more comprehensive than what is listed below as a sample):

CORE SERVICES		
CONSULTING		
Program design evaluation Advice and recommendations Funding alternatives Plan implementations Strategic planning	Vendor evaluation Ancillary program review and design Network discount comparisons Cost projections and budgeting	Contribution strategy and modeling Establishment of disease management and wellness programs with carriers
FINANCIAL AND DATA ANALYSIS (AS AVAILABLE)		

CORE SERVICES		
Ongoing actuarial support Monthly loss ratio review Reserve/lag analysis	Utilization and cost trends Funding analysis	Financial accounting and budgetary reconciliation Trend analysis
BENCHMARKING		
"Profile" reports — industry, geographic and size comparisons	Peer group comparisons	
BROKERAGE		
Plan placement Carrier/market evaluations Performance guarantee benchmarking	Contract renewals Cost comparisons	Aggressive negotiation of costs, terms and conditions Network evaluations
LEGISLATIVE COMPLIANCE		
ERISA attorneys on staff Newsletters and bulletins	ERISA and IRC Code compliance assistance	State mandate updates
COMMUNICATIONS AND OPEN ENROLLMENT (OE)		
Communications/education strategy Communication of OE milestones with vendors	Assistance with drafting and technical review of OE communications	Coordination of annual benefits fairs Development of OE project plans Development of OE presentations
DAY-TO-DAY ASSISTANCE AND SUPPORT		
Plan benefit interpretation Claim issue resolution Vendor monitoring	Administrative issue resolution Compliance issue resolution Assistance with open enrollment	Liaison with vendors Form 5500 preparation

Mercer Advantage

When it comes to health and benefits advisory services, we know that you have many options from which to choose. Why do so many clients choose Mercer over other consulting partners? Because as organizations grow and increase in complexity, Mercer is unmatched in providing the support necessary to help optimize your success. By partnering with Mercer, the Customer not only receives highly effective brokerage via purchasing power that garners the best deals in the marketplace but also strategic consulting on innovative, compliant and easily administered plans that truly engage your employees. Our brokerage

and consulting services and unparalleled depth of supporting resources are scaled to help you maximize the return on your benefits investment and provide optimal value for your organization — all through a highly customized, high-touch approach designed to meet your unique objectives.

Best of Both Worlds

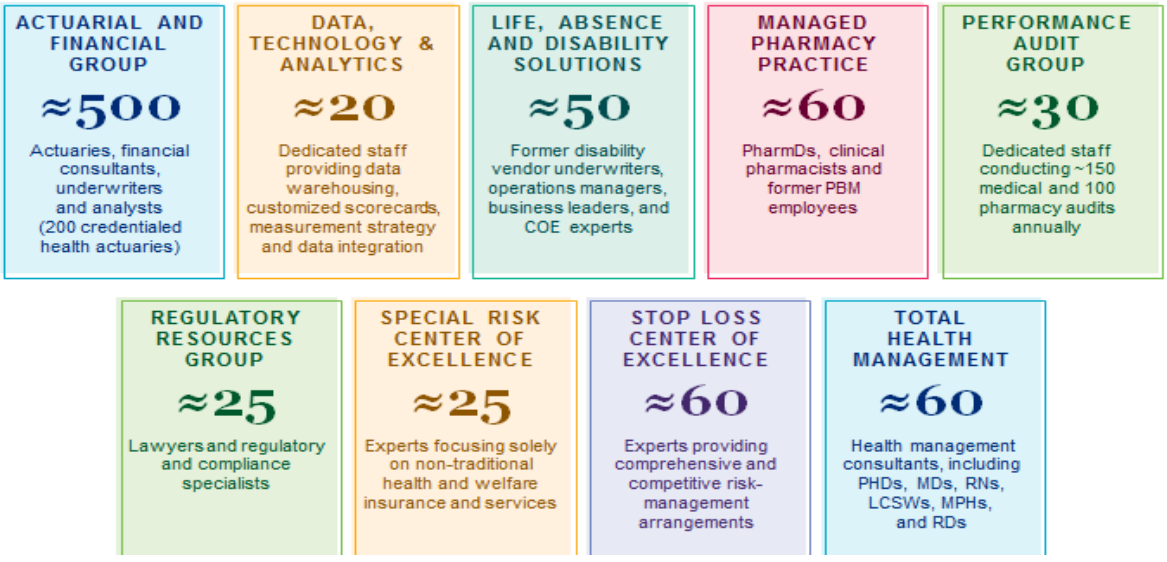
Healthcare strategy is at the heart of our business. Our experts span every aspect of healthcare — general HR strategy, consumerism and wellness, finance and actuarial science, clinical and health management, pharmacy, operations and more. We monitor the benefits landscape, the impact of evolving compliance requirements and individuals' evolving needs. By offering innovative health benefit strategies and alternatives, we keep our clients at the forefront of any changes. This includes developing new client strategies that address evolving requirements.

Our core team members are well versed in the Florida market — and vendor marketplace — through our work with many clients of a similar size to the Customer. We use our proprietary **Strategy for Action** approach (described in the *Proposed Solution* section) to develop a multi-year benefits strategy aligned with your financial objectives, guiding principles, overall reward programs and resource considerations. The result is a clear, integrated strategy that minimizes risk today and takes advantage of opportunities in the future. Ongoing, we'll monitor your strategy against the changing benefits landscape, the continued impact of healthcare reform and your evolving needs.

The commitment, experience and proactivity of our team is enhanced by the expertise, intellectual capital and thought leadership of Mercer's expansive **national organization**. Together, these are powerful strengths that deliver big results for our clients in every segment of the marketplace.

Deep Bench

To help our clients achieve their benefits goals, Mercer's Health consultants are supported by a deep bench of subject matter experts in the following areas, some of which are discussed later in our response:



With these resources, we'll help you develop a thoughtful, relevant benefits strategy for your toughest challenges. You can breathe easy with the assurance that you're accessing what your workforce needs today, along with innovations that keep you competitive and help you stay ahead.

Mercer Muscle

Our position as one of the world's largest benefits brokerage/consulting firms gives us a **leading market share** with nearly every major group carrier and national administrator. This gives the Customer unparalleled access to, and leverage in, the benefits market — enabling you to reap maximum value from the premium dollars you invest in your plans. Our team will tap into Mercer's **Carrier Relations group**, which leads several programs to maximize vendor engagement. This includes our **Service Provider Program**, an arrangement with more than 50 vendors through which clients can access supplemental, advantageous services and products. You can also maximize purchasing power through Mercer's **pharmacy collectives**, including three in the midmarket space, as well as our **stop loss coalition**, which provides access to cost-effective stop loss coverage and an opportunity to share in the profits of the coalition vendor. As industry leaders, we're involved in collective purchasing solutions, pharmacy, telemedicine, stop-loss collective purchasing and consumer-directed health plans. We also created our own health benefits management platform, **Mercer Marketplace 365+**[SM], for employers of various sizes, offering health and non-health benefits such as auto, home and pet insurance. To our knowledge, we are the only firm providing a full range of bundled services that are appropriate for employers of all different sizes — including those with 100 employees, those with more than 100,000 employees and everyone in between.

Innovation That Fits

When you work with Mercer, you'll find innovation reflected in our everyday culture. With our unique expertise and leverage, we ensure that the latest ideas are presented to our clients. We will work together with you to seize opportunities and guide your organization and people toward a better future.

Our **Center for Health Innovation (CHI)** is a testament to our commitment to innovation. CHI team members focus solely on innovation — leveraging our industry leading research and collaborating with our clients, Mercer consultants, and other stakeholders — they develop and deliver innovative, market-leading solutions that are relevant to all employers. CHI also features a dedicated group of consultants focused on conducting market research and analysis to identify innovative start-ups and vendors that hold the potential to meaningfully transform health and well-being strategies and programs.

➢ 3. No Transition Issues or Risks, and a History of Proven Value and Commitment

A change of professional advisors can bring about a lot of challenges to be considered, with many possible risks or unexpected pitfalls along the way. We have worked with you on a significant portion of the requested services, and staying with Mercer means:

- **Avoiding the risk of substantial consulting fee increases with a new advisor** that could occur through charges for a "new or out-of-scope" project that Mercer has done before; uncertain ultimate fees independent of quoted hourly rates with unknown efficiency, billing strictness, unwillingness to invest / partner, lack of staff resources to leverage, transition time and costs, and additional costs from conducting engagements without the benefit of previous strategy and project background and materials plus, you already know the typical fees produced by our hourly rates.
- **No loss of continuity with vendors,** history, claim audit commitments and follow-up, data used in various audit and reform initiatives, existing confidentiality and consultant / vendor authorization, HIPAA and online data access and agreements.
- **Very importantly, elimination of transition time for your staff** at a time when your business operations may not have the extra benefit resources required to engage, monitor and manage a new consulting service provider.

Your partnership with Mercer ensures continued access to the highest level of expertise in the business. While you can trust Mercer's commitment to help you minimize risks during any transition, by retaining Mercer you will continue to receive access to responsive urgent service timing, updates to prior analysis, and confidence that we will deliver what we promise.

Additional Capabilities

Mercer has numerous specialty areas that play a pivotal role in supporting major, complex clients like the State of Florida. **Each of these specialty areas has a unique set of capabilities**. Below, as an example of one of these areas, we highlight and expand upon the capabilities of our pharmacy practice (Audit and Actuarial are expanded upon in those separate Attachment D Technical Proposals). There are many more specialty areas within Mercer besides this highlighted area with similar dedication, focus, and experience in all of them.

Managed Pharmacy Practice (MPP)

Mercer's senior leadership recognizes the critical importance for having the right pharmacy resources to address client needs with the growing importance of Pharmacy in the healthcare benefit plans. As a result, the Pharmacy practice has expanded from 17 people to 62 people (including 20 pharmacists) in the last 10 years.

The new staff that joined brings a wealth of experience from their previous employment, which includes other benefits advisory firms, PBMs, pharmaceutical companies, health systems, and medical carriers. As a result of this diverse staff, MPP has the resources and expertise to assist on any project or question regarding the pharmacy space. In addition, Mercer always adds financial and pharmacy actuary talent to increase rigor and expertise in our financial modeling.

Mercer focuses on providing the highest quality in our consulting services. Quality consulting relates to the content of our work – ensuring that we diagnose our clients' problems correctly and develop practical recommendations. Mercer has an organization-wide commitment to quality assurance through training, peer review, and professional standards.
We ensure quality in our operations – and differentiate ourselves from our competitors – in the following ways:

1. **Mandatory Peer Review –** Mercer requires all substantial consulting work be reviewed by a qualified independent professional before being released to the client.

2. **Professional Development –** Our professional development program takes a strategic focus, targeting ongoing training activities for both senior and junior staff to individual developmental needs and organizational objectives.
3. **Client Management Training –** Senior consultants attend special courses on the integration of skills needed to successfully manage major projects and build mutually rewarding client relationships in multiple service areas.
4. **Client Appraisals –** Our clients are our most important source of information about quality performance. Our senior people meet with clients periodically to evaluate our work. On a national basis, we regularly survey our clients on their satisfaction with the technical and service quality of our work.
5. **National Business Leadership Groups –** These groups are responsible for establishing professional standards within our consulting and service disciplines. They also serve as focal points for planning and reacting to external events, such as new legislation, so that we can advise clients quickly and accurately.
6. **National Professional Affairs Committee –** This group is responsible for establishing and enforcing professional standards that apply across all of our consulting and service disciplines.

Mercer's MPP also fully reflect the three differentiating key aspects of Mercer's market leadership: leverage, expertise and innovation:

- Our leverage has been previously outlined in this document. It comes from the billions of healthcare and pharmacy dollars that our clients spend and that we help manage. This spend represents a diverse clientele and includes public sector entities like states, school districts, and counties.
- Our expertise is demonstrated by the breadth and depth of experience of our staff. Mercer's 20 clinical pharmacists on staff represent one of, if not the largest, concentration of clinical talent in the consulting world. Additionally, we regularly interact with physicians, actuaries and health improvement experts throughout Mercer to build solutions that maximize the return on investment for the pharmacy and healthcare benefit.
- Our innovation is represented by the diversity of solutions we have, and continue to develop, including clinical solutions like specialty drug carve-out and evidence-based design, as well as financial solutions like our recent partnership with Xevant for managing cost trends.

Mercer is one of the leading public healthcare consulting organizations in the industry, and when combined with our widely recognized name and expertise in the market, provides our public groups with strong and instant credibility with their constituents. These credentials, in addition to the strong pharmacy credentials previously described in this section, provide Mercer with the uniquely strong capabilities to assist the Customer.

Your Mercer Team

Mercer's size and scope allows us to bring the Customer a combination of personal service tailored to your needs supported by the power of national intellectual capital and resources. Your core Mercer team members are able to respond swiftly to your day-to-day needs and to meet with you in person on short notice, as needed.

The proposed team for the Customer comprises carefully chosen professionals with the experience (including government clients), technical expertise and tactical management skills needed to meet your goals and requirements. Most of our proposed team members noted have more than twenty years of experience, direct experience working with the Department, and understand the Department's benefit programs as well as the need for flexibility and responsiveness. Most proposed team members reside in our Atlanta (region specialty hub) or our Florida offices. The team will be supported by appropriate supporting technical and consulting staff from our national, regional and local specialty and general staff, as needed. With this depth of expertise, the Customer can be confident that Mercer will meet your dynamic and multi-faceted needs — both today and tomorrow.

Keith Hanson, your Client Relationship Manager and Strategic Advisor, and as a senior member of our healthcare practice, has the authority and ability to structure the team to meet your individual needs in all areas of the engagement, without organizational constraints. He will work hard to ensure your full satisfaction with our services and will be a central, overarching point of contact for any significant and/or escalated issues or questions that arise. He has experience working with organizations of the Customer's size and in your industry and will be sure to deploy the right resources at the right time. He will work closely with our core team members and specialists who will help you meet your needs and requirements in key areas.

A summary of proposed team members and their associated roles and experience are provided in the table that follows. Full biographies for all team members are available upon request.

TEAM MEMBER	ROLE/RESPONSIBILITY
Keith Hanson, CEBS Principal	**Client Relationship Manager and Strategic Advisor** Responsible for Mercer's overall relationship with the Customer, ensuring seamless service delivery, monitoring team performance, providing problem resolution and ensuring overall quality control
Robin Hagerty, FSA, MAAA Partner	**Executive Sponsor** Atlanta Health Practice Office Business Leader who ensures team members have access to the full breadth and depth of Mercer's resources to meet the Customer's needs
Matthew Snook Partner	**Florida Health Plans Advisor** Senior leader in our Florida market healthcare practice and can provide state and local insights on legislative, employer, vendor and market activity
Joe Badalamenti, FSA Partner	**Health Consultant** Senior leader responsible for the delivery of health and benefits consulting services
Rosalind Britt Principal	**Health Consultant** Senior leader responsible for the delivery of health and benefits consulting services

TEAM MEMBER	ROLE/RESPONSIBILITY
Ben Rayburn, FSA, MAAA Principal	**Health Lead Actuary** Senior resource responsible for managing all actuarial requirements for this project
Katelyn Mitchell Analyst	**Health Analyst** Under the guidance of lead and supporting consultants, executes all strategic decisions and serves as a day-to-day resource
Lisa Oswald Principal	**Pharmacy Audit Lead** Senior leader responsible for oversight into material development, conduct evaluations and co-develop report finding and recommendations.
Terry Dailey, JD Partner	**Compliance Lead** Senior legal resource that advises employers on compliance issues associated with health and benefits plan design, reporting, plan governance and administration
Paola Guyer Principal	**Project Lead, Workforce Communication and Change** Senior resource responsible for developing employee engagement strategies that can help the Customer's employees understand, appreciate and effectively use their benefits package
Jonathan Pas Principal	**Total Health Management (THM) Lead** As Mercer's East Region THM Leader he develops health management and wellness strategies to meet the needs of the Customer's growing workforce
Mike Bailey Principal	**Life, Absence and Disability (LAD) Lead** Senior resource providing strategic guidance and direction for the Customer's life, absence and disability projects
David Dross Partner	**National Practice Leader, Managed Pharmacy Practice** Pharmacy Team Executive Sponsor responsible for all portions of pharmacy engagements
Debbie Doolittle Principal	**Pharmacy Project Lead** Senior resource responsible for leading all facets of pharmacy projects including PBM evaluation, contracting, and negotiations with the designated service team and any additional needed services
Sherry Welliver, PharmD Principal	**Pharmacy Clinical Lead** Oversees the clinical aspects pharmacy projects as well as providing clinical support during the evaluation and negotiation phases
Grace DiLello Principal	**Pharmacy Financial Lead** Responsible for guidance and analysis of all financial aspects of pharmacy projects. Has worked on dozens of large procurements in both the private and public sector.

As described in the Experience section, Mercer is well-suited to provide the services requested in the Benefits Consulting Service Categories. The proposed team members for the Customer have the requisite skills and experience to deliver all items listed in the Scope of Work, including the Tasks outlined in Section 2.5.1 of the RFP.

PART 2: PROPOSED SOLUTION

As described earlier (please refer to the "your Mercer team" section in the Experience part of this document), Keith Hanson will lead Mercer benefits consulting services projects for the Customer. Working together Keith, Joe, Rosalind will develop strategy and determine the appropriate resources, including additional qualified team members to meet/exceed Customer's needs for each specific project.

Mercer's Five-step Consulting Process

Health and benefits play a central role in creating an engaged and healthy workforce. To help your benefits programs attract the best people and meet their evolving needs, it is essential that Mercer gather and use input from the Customer to arrive at the best fit solution for you. We will partner with you to develop a deep understanding of your industry, business strategy, reward strategy, growth projections, and goals. Based on this input, your consulting team will identify best practice alternatives, and will work with you to arrive at the optimal program to offer to the Customer employees.

Using our ***Five-step Consulting Process***, we'll design a short- and long-term strategic plan and solutions that help you achieve your goals. This efficient process draws on our proven guidelines, tools and resources to bring you better value and outcomes for your people. Here's how our Five-step Consulting Process works:

Step One: Understand. The first thing we do is learn as much as possible about you — your business context, leadership and employee views; the competitiveness of your benefits; and your benefits costs and utilization. We'll keep track of this information in our **Strategic Placemat**, an evolving tool, shown below, that we'll use and reference consistently to guide your strategy.

Step Two: Strategize/Analyze. Next, we'll work together to:

- ***Develop guiding principles*** to shape your benefits strategy and make sure that it continues to address the needs of your people and your business.
- Use information gathered in Step One to ***create a strategic framework*** by completing all sections in the Strategic Placemat: Environment, Guiding Principles, Strategy, Actions, Barriers and Success Measures.
- Assess the return on your investment (ROI) — in both hard and soft dollar costs — to help your company leaders ***understand the long-term value*** of your benefits strategy.

Step Three: Design. After your strategy is refined, we'll build your program design. Based on our findings in our first two steps, we'll offer you a range of program options that meet your needs and goals. This will include in-depth financial analysis of potential ROI. We'll work closely with you to make sure the final program design is aligned with your benefits strategy. In this step, we will also work with you to create a multi-year strategic roadmap.

Step Four: Implement/Manage/Measure. Next, we'll implement your plan design. During this phase, we'll review your Strategic Placemat; use our project management tools to create a detailed project plan; reconfirm and update your metrics, if needed; execute on your roadmap; and measure your progress, gathering your feedback at key milestones.

Step Five: Refresh. Finally, we'll revisit your strategy as we work together, asking key questions and making any needed adjustments to make sure you're achieving your goals for your employees. We'll perform this step at least annually, but also whenever you have a change with a decision maker, new challenges or opportunities, legislation that impacts your workforce or benefits, or a merger or acquisition that changes your business.

Benefits Strategy: Strategy for Action Framework

Optimal positioning for the future begins by planning today. the Customer will realize significant advantages when partnering with Mercer to develop and execute a multi-year strategic plan.

- We'll use our proprietary **Strategy for Action** approach to thoughtfully develop a multi-year health benefits strategy aligned with your specific financial objectives, guiding principles, and resource considerations. We'll look holistically at your programs to align them with your total rewards philosophy, and leverage our experience to ensure they support your benefits objectives.
- We bring unmatched access to health innovation through our **Center for Health Innovation** and venture capital relationships that identify the advantages of new approaches and the feasibility of adopting them for individual clients. The Center for Health Innovation creates solutions and thought leadership to support an employer-driven transformation of the healthcare market. We solve meaningful problems for employers by collaborating with clients, entrepreneurs, nonprofits, and academia to bring practical and relevant ideas to market. Our CHI members work with the start-up community to connect their vision and ideas with our clients' unmet needs, generating new technology-enabled options. We work closely with our sibling company Oliver Wyman and the Oliver Wyman Health Innovation Center to augment our benefits expertise with their leadership in healthcare delivery transformation.
- You can count on Mercer to be truly collaborative in our work with you, readily accessible and highly proactive on your behalf. In fact, our strategic approach is all about investing time upfront with you to learn about your specific needs, then finding the right solutions that will work in the real world. We'll craft chemistry with the Customer that will build trust between our people, creating the perfect environment to honestly exchange ideas and determine, together, the right way forward. Beyond working hard,

our collaboration means that we'll make time to have a little fun along the way — as we build our partnership in the early days, and as we celebrate our milestones and success in the future.

Innovation and Continuous Improvement

As part of our ongoing work with the Customer, we will partner with you to explore options to introduce innovations and continuous improvement opportunities across all of your benefit programs. During annual planning meetings we will review emerging trends in the market and evaluate their compatibility with the Customer. Examples of opportunities we've explored in the past with other employers include:

- Carving out the Rx/specialty Rx program from medical
- Implementing clinical care management including, but not limited to, enhanced care management programs with existing partnerships, third-party care management programs and carving out care management programs with TPA solutions

The Customer is dedicated to improving the employee experience, and as your partner, Mercer will invite the Customer's participation when unique opportunities and initiatives arise.

Mercer will also review the Customer's existing programs to ensure that costs stay in line with budget and below trend, and that employee experience continues to improve. Any decisions made with regard to the Customer's plans are always though the lens of how we can improve the overall employee experience.

Benefits Renewal Process

The process of renewal involves interfacing directly with vendors on your behalf. Our objective is to negotiate aggressively, fairly and, by using data and facts, to achieve optimal results. Mercer takes a broad view of the renewal, including all phases leading up to the onset of a new renewal plan year. The following describes the specifics of how we will work with the Customer throughout the annual renewal process. In these renewal strategy meetings, we will address questions such as:

- What is your measure of success for your benefits programs?
- How competitive does the Customer want to be with respect to your peer group?
- What are your cost targets?
- Does the current benefit structure support and meet the needs of the employee populations within the Customer from a recruiting and retention perspective?
- Are the current product offerings the right mix? Would different benefits generate cost savings and better meet the needs of the participants?
- Is the current contribution strategy accomplishing its goals?
- What are employees' expectations?
- Is the current communication approach working?
- How are you handling benefits administration? Do the current processes meet your needs?

We use a proprietary framework for exploring actionable cost containment measures. Typically, some combination of three key areas becomes the roadmap for the most appropriate interventions for any given employer: managing costs, improving the experience and optimizing design and administration. Together, we will explore each of these areas to determine which areas are organizational priorities relative to the others. Effective solutions can fall anywhere on the innovation spectrum. The outcome is an identification of the key levers where innovation needs to be explored further to achieve your organizational objectives.

The next step in the renewal process is a complete review of experience, including cost projections that reflect the anticipated impact of any changes under consideration. With data in hand, Mercer will meet with the Customer to discuss the renewal strategy. In this meeting, we will review experience, confirm plan design changes, cost and budget parameters and determine in collaboration with the Customer whether a marketing of plans should be performed. In the meeting we confirm objectives, assign responsibilities and establish time frames for the renewal process.

Assuming no RFP, Mercer prepares the formal renewal request to be sent to the carrier(s). The requested information includes items such as the experience period being used by the vendor, the underwriting methodology (trend, healthcare reform impacts, PCORI fees and reinsurance fees) and identification of high-cost claims included for self-insured programs and pooling points for insured programs. If plan design changes will be implemented, this information is included in the request. The renewal request is reviewed with the Customer prior to being issued to the carrier.

Upon receipt of the renewal from the carrier(s), we perform a barometer check on the results by running the Customer's data through our **Standard Mercer Rating Tool Enhanced Rating (SMRTer)**. SMRTer is our firm-wide, standard underwriting and financial forecasting tool, which we use for budgeting, forecasting and renewal projections for all self-funded clients. The tool also can be used to verify the appropriateness of an insurer's fully insured renewal calculation. We will use the tool to develop premium equivalent rates based on our underwriting methodology and assumptions. Then, we will perform an analysis to compare the SMRTer results with the carrier(s) renewal calculations and prepare a financial breakdown identifying areas of concern or discrepancies for discussion with the Customer and further negotiation with the carrier(s). We will meet with the Customer to present the barometer check and obtain agreement on a negotiation strategy.

Next, we will commence negotiations with the carrier(s) on the Customer's behalf until a best and final offer (BAFO), including performance guarantees, is in hand. We will present the BAFO to the Customer and identify the impact of the negotiations as compared to the initial carrier offer and the Customer's objectives.

Mercer will review the contract to ensure that the terms and conditions agreed to in the negotiation process are reflected appropriately.

Vendor Identification

As one of the world's largest employee benefits consulting firms, Mercer accounts for the leading market share for almost every major group carrier and national benefits administrator. We'll apply that vast market knowledge to help the Customer identify vendor selection criteria and key performance metrics that will be critical to developing and maintaining successful vendor relationships. We'll also identify vendors with the highest potential to meet your needs, assess and evaluate those vendors, and help to negotiate the best possible contract for the Customer.

We have broad capabilities to facilitate and manage the competitive bid process for the Customer for all lines of coverage, including:

- Developing RFP and evaluation criteria for final vendor selection
- Receiving and analyzing all proposals, and preparing a report to review with the Customer
- Working with the Customer to assess proposals based on evaluation criteria
- Selecting finalists and fine-tuning negotiating points
- Conducting finalist interviews
- Negotiate final scope, services, terms and pricing to meet the Customer's requirements
- Notify markets of selected vendors, and establish implementation parameters
- Facilitate implementation plans and monitor process

Initially, we reference such resources as A.M. Best, Standard & Poor's and Moody's to confirm the financial strength and stability of potential vendors. All information is gathered from sources considered reliable, but Mercer cannot guarantee the accuracy of such information.

During the vendor marketing process, we focus on several key areas, while considering category weightings established by our client:

- **Fixed costs** to administer the plan.
- We benchmark administrative service only (ASO) fees relative to employers with a similar basket of services using our ASO Fee Benchmarking Tool. This robust database provides benchmark data for more than 1,000 organizations across the US. The ASO tool includes data on base ASO fees, as well as fees for utilization review, pharmacy, banking, nurse line, behavioral health and many other common administrative fees. It enables us to get a clear picture of the competitiveness of your fee arrangement to support effective negotiation during renewals and marketings.
- Many of our clients use stop-loss coverage to manage volatility risk. Mercer's Stop Loss Center of Excellence focuses on the trends, nuances and innovations in the stop-loss market, allowing us to provide best-in-class consulting and risk mitigation for clients. Our Stop Loss Coalition has collective arrangements with top-quality reinsurers with best-in-class provisions. We apply our expertise from our collective work to evaluate your existing arrangement and assess proposals — helping you manage year-over-year cost increases and adverse contractual arrangements.

- **Medical**, **dental** and **pharmacy claim costs**, which make up the majority of expenses under all coverages, driven by:
- **Provider and retail/mail order discounts:** Using proprietary tools such as NetPiC for both medical and dental networks, we measure relative provider reimbursement among the major carriers and plans (including the most cost-efficient networks), based on your geographic footprint and claims distribution. While reimbursement rates are an important consideration, total plan cost is of greatest importance to the plan sponsor. To this end, we recently released NetPiC 2.0, which complements NetPiC by looking at risk-adjusted total cost of care by geography. For pharmacy pricing, we leverage our RX Pricer tool to evaluate the impact of discount and pass-through arrangements.
- **Provider and pharmacy access (breadth):** We access national survey data to evaluate the adequacy and comparative depth and breadth of provider/pharmacy networks. This information helps to determine whether a change in carriers is feasible.
- **Provider and pharmacy disruption (depth):** We analyze potential disruption to members from changing providers and focus on provider types of particular importance to participants, such as pediatricians, OB-GYNs and primary care physicians. This information, combined with provider reimbursement levels and access results, enables us to provide you with a financial comparison of vendor networks and the potential impact to employees. For pharmacy networks, we evaluate disruption using data from our Pharmacy Benefit Managers.
- **Service capabilities and performance:** Our **Performance Audit Group** (first described in the *Experience* section of our proposal) is one of the largest and most experienced groups of its kind in the US. Through this group, we can access a wealth of claims and operational audit results comparing vendor performance, benchmark standards for measuring performance, and best practices for evaluating operations. Leveraging this information, we are able to evaluate vendor performance (including performance in specific geographic locations) relative to best practices and negotiate best-in-class performance guarantees.
- **Clinical care management programs:** We continue to make significant investments in enhancing our resources and tools in this area. Our **Total Health Management** practice assesses the care management capabilities of the major carriers and carve-out vendors, and the incremental value of their approaches. Leveraging this information and using robust modeling tools, we can evaluate the potential value of a carrier's care management services. This information, combined with the other components of vendor evaluation, helps to provide a deeper assessment of the value of one carrier over another.

The strength of Mercer's **Actuarial and Financial Group (AFG)** (first described in the *Experience* section of our proposal) supports the activities above. Comprising financial experts and actuaries, the AFG develops proprietary financial tools for our consultants to use in modeling the reasonableness and financial impact of potential carrier changes. They also help our consultants to identify areas of risk from change and to think through solutions to minimize such risk.

Changing carriers is a substantial process requiring a considerable level of coordination among the new vendors, the Customer and your consulting partner. Mercer has a tremendous amount of experience assisting our clients with vendor transitions. We use our comprehensive work plans and checklists that have been compiled through years of managing transitional activities and also leverage the implementation team that is part of all top-tier vendor transition teams. The value of leveraging these resources is that they know the vendor's internal systems, processes and workflows and will be able to facilitate the process from the inside. Maintaining a competitive benefits program while managing costs is an active process that requires continued attention. Our initial focus will be to help the Customer refine your overall benefit strategy. We will help you evaluate approaches that can maximize cost savings and return on investment based on your unique situation.

The Right Benefits

To help identify "best-in-class" benefit program designs for the Customer, we focus our thinking on what's evolving in the marketplace and what we expect to happen in the future. We work to identify rapidly evolving industry trends and compare your benefit plan data with industry, peer group, regional and national survey data to help identify best practices. This helps us to show you the whole picture, so that we can improve the quality and competitiveness of your benefits.

Our proprietary benchmarking tools include:

- Mercer *National Survey of Employer-sponsored Health Plans*
- Mercer *Survey on Absence and Disability Management*
- HERO Health and Well-Being Best Practices Scorecard in Collaboration with Mercer®
- Benefit Valuation Analysis (BVA)

Mercer *National Survey of Employer-sponsored Health Plans*

Established in 1986, our annual *National Survey of Employer-sponsored Health Plans* is one of the largest and most authoritative health benefits surveys. Each year, approximately 2,500 employers answer detailed questions about their health plans, with a focus on cost-management strategies including consumerism and employee well-being, with separate questions on retiree medical benefits. We use a national probability sample of US employers with 10 or more employees (including local and state governments), stratified by employer size and region, to ensure a representative mix of employers. To our knowledge, this is one of only two representative ongoing benefit surveys of US employers (the other is from the Kaiser Family Foundation).

The results of our survey provide comprehensive data on employer health plan offerings and cost, as well as detailed plan design information for PPOs, HMOs and consumer-directed health plans (CDHPs). Each year, we produce a report of survey results and an appendix of data tables showing responses to many questions by region, industry group and employer size. As our client, you have access to 200+ data cuts from the survey as well as customized reports based on selected cuts of data at your request.

Mercer *Survey on Absence and Disability Management*

The Mercer *Survey on Absence and Disability Management* provides comprehensive benchmark data on the full range of time-off benefits, including sick leave, disability programs, FMLA, holidays, vacation, workers' compensation, PTO plans and other leave benefits including parental and adoption leave.

With a focus on strategies for reducing costs and improving administrative efficiency, this survey is designed to help employers identify and address the impact of absence on their operations. Detailed plan design data is also collected to allow employers to benchmark their programs against those of similar organizations. In 2018, more than 420 employers participated.

HERO Health and Well-being Best Practices Scorecard in Collaboration with Mercer

Together with the Health Enhancement Research Organization (HERO), we designed this online survey tool to reflect the best thinking on what makes a successful total health management program. The HERO Scorecard can be used as an inventory to identify gaps and opportunities, compare your program to industry best practices, assist you with in strategic health management planning and take your health and well-being program to the next level. Once you complete its more than 60 questions, the Scorecard provides instant results you can compare with national averages, and use as a baseline for year-over-year comparisons.

Benefits Valuation Analysis (BVA)

BVA is the core tool Mercer uses to compare the value of the benefits you offer versus a custom peer group(s). The report generates a common dollar value for benefit plans with varying plan designs and provisions. Statistical comparisons are then made to create an objective "apples-to-apples" comparison of your plans to those of the peer group. The BVA report results reveal how each of your plans compares to the peer group for your employees as a whole using a sample workforce/census population to maintain consistency among the values. The BVA organizes benefit plans into three major categories outlined below, then breaks down the comparison further, focusing on each specific benefit:

- Health/Group (medical, post-retirement medical, dental, life, and flexible spending accounts)
- Retirement/Savings (defined benefit, defined contribution, stock purchase)
- Time Loss (vacation, holiday, personal leave, sick days, STD and LTD)

The Right Vendors

To help ensure you get the most for the benefit dollars you spend, we use our proprietary tools and resources to identify the vendors that will bring the most value to the Customer.

Network Provider Contracting (NetPiC)

NetPiC is Mercer's proprietary model that estimates which carrier's provider discounts produce the lowest covered charge for a given employee population. Using information previously unavailable to our consultants, Mercer's actuaries developed the NetPiC methodology to overcome the shortcomings of traditional approaches and to provide health plan provider fees

on a more comparable basis than ever before. The results from this analysis are critical in helping clients to select an appropriate health plan network.

NetPiC provides a consistent methodology for analyzing provider contracting arrangements based on a client's geographic and medical service utilization distributions. The model calculates expected relative reimbursement levels in competing carrier networks for inpatient facility, outpatient facility and professional medical claims. The actuarial model is driven by a robust dataset of a vendors' regional and national book of business provider contracting data. Mercer gathers this data periodically from carriers that respond to our data request. Our highly specific and detailed request format helps to ensure consistency in submissions. Each carrier's chief actuary must certify that their submission accurately reflects the carrier's provider reimbursements. Once we receive the information, we process it and send reports for carrier validation. We often load the data into a database to use with our actuarial model.

We analyze total calculated covered expense for each major carrier to compare savings opportunities by vendor and location, assessing claims data for each three-digit ZIP code inhabited by at least one employee or retiree. We calculate eligible charges before discount, covered charges after discount but before plan design has been applied (that is, deductibles, co-payments and coinsurance) and the units (for example, number of procedures) associated with the charges above. Once completed, we provide a report summarizing our analysis.

We use NetPiC to evaluate network discounts for about 300 employers each year.

NetPiC 2.0: As the provider and network landscape has evolved, so too our tools have evolved to keep pace. Mercer recently launched NetPiC 2.0, a risk-adjusted total cost of care model. While provider contracts and discounts continue to play a meaningful role in controlling costs, carriers bring many other levers to the table as well. NetPiC 2.0 measures the overall effectiveness of a carrier in managing cost by looking at the total claims cost in a specific geography, with an adjustment for the overall morbidity burden of the underlying population.

Performance Audit Group

As first described in the *Experience* section, Mercer's **Performance Audit Group (PAG)** provides access to a wealth of claims and operational audit results comparing vendor performance, benchmark standards for measuring performance and best practices for evaluating operations. Leveraging this information, we can evaluate vendor performance relative to best practices and help identify the best vendors for our clients.

Service Provider Programs

As discussed in the *Experience* section, Mercer's Value Service Provider, Select Service Provider and Market Service Provider programs help our clients access supplemental, advantageous services and products not typically available on the open market.

Our process for adding vendors to these programs is comprehensive, and participation in the program is renewed on an annual basis to ensure we are getting the best and most current enhanced service offerings for our clients at all times. In addition, we survey our national

network of more than 1,000 colleagues to ensure that these firms are delivering services at a level commensurate with the designation.

Plan Design Modeling

With our statistically founded proprietary analytical tools we are able to perform all financial analyses for the Customer with reliability. We use these tools to identify claim trends and cost drivers, forecast future healthcare costs and analyze plan design/funding alternative options so that you can make accurate, timely decisions.

MedPrice is Mercer's firm-wide pricing tool for evaluating the impact of plan design changes. It provides a great deal of flexibility to accommodate complex plan designs and can be customized to reflect client-specific claim distributions and demographic characteristics.

MedPrice's underlying claim distribution is updated annually based on a proprietary database of national Mercer clients representing billions of dollars in covered claims. The model re-prices claims based on the underlying data and your specific plan design provisions providing highly accurate results. Relative value modeling is run on an automated server, so consultants can evaluate plan designs quickly and without generating fees to use the model. We also maintain a group of designated MedPrice power users who are available to answer colleagues' questions and to assist with complex analyses.

In modeling plan designs, we do not focus only on the costs to the plan. We also pay close attention to the impact on member out of pocket costs. In today's world where patients are increasingly responsible for a meaningful portion of their health costs, we believe it is important to specifically evaluate out of pocket costs and to help employers make informed decisions about the total amount of employee cost sharing under their health plans taking into account both out of pocket expense and payroll contributions.

For a very large or sophisticated client, we can build a client-specific plan modeling tool customized to match key population characteristics such as family size, in- and out-of-network spending and claim distribution, and allow direct modeling at a high level by the client's team.

In terms of philosophy, we are not predisposed to any particular design structures. We understand that each employer has its own set of beliefs and constraints regarding access, disruption, choice, patient-responsibility, employee cost sharing and acceptable levels of benefit spending. We believe we can best serve our clients, and in turn our clients' employees, by designing benefits specific to the situation and constraints at hand in a manner that maximizes the value of the benefits both to members and to the plan sponsor.

There are potential significant legislative changes that may impact the "tax optimization" of plan offerings and marketplace benchmarks and trends. An important part of our role is working with our clients to understand these changes and market direction to plan for the future. Our strategic consultants, actuaries and legislative experts are working together to monitor these changes and advise our clients quickly and effectively on potential impact on future plan offerings and strategies and market direction.

Legal Resources

We have two groups of legal professionals that track legislative, regulatory, judicial and policy activity related to employer-sponsored health and welfare plans. These groups work proactively to keep our consultants and clients informed of such activity and develop practical strategies for employer-plan sponsors to comply with new developments in the laws, regulations and sub-regulatory guidance impacting their health and welfare plans.

Regulatory Resources Group (RRG) — With approximately 25 lawyers and regulatory compliance specialists, Mercer's RRG staff are imbedded in the local office consulting teams to deliver technical and regulatory compliance support, tools and services to make sure your health and welfare plan designs, operations, and transactions comply with applicable laws and regulations from a practical, risk management perspective. We have assigned Terry Dailey as a member of the Customer team.

Law & Policy (L&P) Group — L&P is a team of lawyers, actuaries and technical experts who analyze health, wealth and global legislative, regulatory, judicial and government relations issues. We have the insight, relationships and experience to provide expert analyses on a variety of US, state and global compliance and policy matters. We develop leading-edge intellectual capital — like GRISTs and the monthly Global Legislative Update — valued by Mercer consultants and clients alike. Our collaborative process enables us to provide concise and "reader-friendly" articles that highlight relevant information, analyze legal issues and give specific action steps or considerations. L&P partners internally across Mercer's lines of business to help clients address their most complex issues. In the US, we specialize in federal and state benefit and leave laws, including relevant tax, actuarial and accounting issues. Our US coverage focuses on health and welfare plans for active and retired employees, including all aspects of the ACA.

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TECHNICAL PROPOSAL (ATTACHMENT D)
SERVICE CATEGORY 2 – ACTUARIAL

REQUEST FOR PROPOSALS - NO. 19-801111502

As required by the RFP, Mercer's Technical Proposal contains two parts and are submitted separately for each Service Category:

- **Experience:** focuses on Mercer's capabilities in the Service Category and the qualifications of the specific team members who will deliver the services to the Customer.
- **Proposed Solution:** describes our processes and approach for delivering the requested services in the Service Category.

PART 1: EXPERIENCE

Mercer has been providing health and benefits services for more than 80 years. Our US Health business comprises nearly 2,500 employees, and serves almost 4,000 clients. With one of the largest groups of seasoned experts with knowledge and experience spanning every aspect of healthcare, Mercer is well-positioned to provide all of the services requested in each of the three Service Categories: Benefits Consulting, Actuarial and Claims Auditing. A general description of our firm's capabilities in addition to those in the Actuarial Service Category is provided below, along with information about the core team members who will provide the services to the Customer (as reflected in the RFP we have used the general term "Customer" throughout our proposal to reflect all state agencies and eligible users for this Contract).

Mercer believes there are three (3) primary reasons that we are uniquely capable of assisting in achieving your goals and objectives:

- We know your industry/state governments, your program, vendors, the market, and you/Customere
- We Bring Unequaled Expertise, Capabilities, and Approach
- No Transition Issues or Risks, and a History of Proven Value and Commitment

➢ 1. We know your industry/state governments, your program, vendors, market, and you/Customer

Knowing Your Plans, Vendors and History, Uniquely Qualifies Us to Meet Your Needs

Over the years, Mercer has worked with you to ensure delivery of effective strategies and solutions. We have helped you define your principles, key issues and strategic priorities. We have shown we can work quickly with you to identify, craft, and validate new solutions to meet your current and future needs. We pride ourselves on delivering high-quality advice; services and solutions that have helped the State of Florida facilitate discussions and produce results.

Your Mercer team knows you and your history, allowing us to effectively revise or leverage prior work with minimal cost and transition time. In the past few years, we have provided support to the State of Florida including the following initiatives:

- **Numerous actuarial modeling projects, including pricing, review, analysis of alternative designs and contributions, and impact to overall budget**
- Medical plan analysis and procurement consulting
- Pharmacy plan analysis, renewal negotiation guidance, and PBM procurement consulting
- Benchmarking (our survey resources are well known and considered the "gold standard" in the industry
- Pharmacy performance and operational audits
- **Healthcare reform actuarial modeling**
- **HMO plan referral pattern analysis (in depth data analytics project) and actuarial modeling**
- Compliance support (Mental Health Parity review)
- Persona cluster analysis
- MAPD consulting
- Legislative support

As we look ahead, Mercer is uniquely positioned to help you both ***cost-effectively*** apply those strategies and tactics previously identified as valid and ***quickly take a fresh look*** for building new ideas that enhance your benefit and total rewards programs.

➢ 2. We Bring Unequaled Expertise, Capabilities, and Approach

OVERVIEW: ACTUARIAL CAPABILITIES

Mercer's US Health business includes approximately 175 credentialed actuaries. They have experience in all aspects of financial and analytical support pertaining to healthcare program strategy and management and serve as the sounding board for developing strategic initiatives, making sure the financial implications of our consulting advice are considered and vetted before presentation to the client. Outside of strategic projects, our actuaries provide traditional support (such as, periodic certification of IBNP reserves, development of self-funded premium equivalent rates, development of employee contributions, HMO rate negotiations, experience versus budget monitoring, and analysis and diagnoses of unexpected variations in experience and delivery of proposed remedial actions), specialized support (such as, PBM and Specialty Drug diagnostics, Care Management strategy modeling and long-tail liability valuation) and more innovative support (such as, developing new vendor performance measurement techniques, performance metrics for new initiatives/pilots, program dashboards and overall population health status indices). Lead actuaries serve as the day-to-day contacts for our clients' finance, accounting and analytical staff and are available to benefit staff for all financially oriented needs. The lead actuary will also engage additional actuarial and financial resources, as needed, so that all findings and results are comprehensive and fully compliant with all internal and external professional standards.

In addition to the local actuarial and financial professionals assigned to your account, the Customer will be supported by Mercer's national financial resources.

Actuarial and Financial Group (AFG)

Just as we collaborate with our clients, we collaborate internally, sharing best practices, creative ideas and the most current available tools. Our collaboration also helps us to focus on developing and using actuarial and financial standards of practice. Our **Actuarial and Financial Group (AFG)** — which includes more than 500 health and benefits actuaries and financial consultants (such as, underwriters and analysts with specific training and experience in health and welfare strategy) — is dedicated to this creative, constructive collaboration.

Led by our Chief Actuary, the AFG makes it a priority to support the development of actuarially and financially focused intellectual capital, consulting guidelines and standards of practice, and tools and other financial resources. As such, the group is responsible for responding to emerging topics (for example, healthcare reform, consumerism and alternative network strategies), networking with key interest groups and sharing best practices.

The Customer will have access to support from this team of experts through our core services.

Standards, Guidelines and Checklists

The AFG has various standards, guidelines and checklists in these areas of expertise as well:

- COBRA pricing
- Consumer-driven health plans
- Credibility measures
- Incurred-but-not-paid (IBNP) liabilities
- Peer review
- Pricing factors
- Retiree medical and life benefit valuation
- Stop loss placement

Mercer Advantage

When it comes to health and benefits advisory services, we know that you have many options from which to choose. Why do so many clients choose Mercer over other consulting partners? Because as organizations grow and increase in complexity, Mercer is unmatched in providing the support necessary to help optimize your success. By partnering with Mercer, the Customer not only receives highly effective brokerage via purchasing power that garners the best deals in the marketplace but also strategic consulting on innovative, compliant and easily administered plans that truly engage your employees. Our brokerage and consulting services and unparalleled depth of supporting resources are scaled to help you maximize the return on your benefits investment and provide optimal value for your organization — all through a highly customized, high-touch approach designed to meet your unique objectives.

Best of Both Worlds

Healthcare strategy is at the heart of our business. Our experts span every aspect of healthcare — general HR strategy, consumerism and wellness, finance and actuarial science, clinical and health management, pharmacy, operations and more. We monitor the benefits landscape, the impact of evolving compliance requirements and individuals' evolving needs. By offering innovative health benefit strategies and alternatives, we keep our clients at the forefront of any changes. This includes developing new client strategies that address evolving health reform requirements.

The commitment, experience and proactivity of our team is enhanced by the expertise, intellectual capital and thought leadership of Mercer's expansive **national organization**. Together, these are powerful strengths that deliver big results for our clients in every segment of the marketplace.

Deep Bench

To help our clients achieve their benefits goals, Mercer's Health consultants are supported by a deep bench of subject matter experts in the following areas, some of which are discussed later in our response:

With these resources, we'll help you develop a thoughtful, relevant benefits strategy for your toughest challenges. You can breathe easy with the assurance that you're accessing what your workforce needs today, along with innovations that keep you competitive and help you stay ahead.

Mercer Muscle
Our position as one of the world's largest benefits brokerage/consulting firms gives us a **leading market share** with nearly every major group carrier and national administrator. This gives the Customer unparalleled access to, and leverage in, the benefits market — enabling you to reap maximum value from the premium dollars you invest in your plans. Our team will tap into Mercer's **Carrier Relations group**, which leads several programs to maximize vendor engagement.

Innovation That Fits
When you work with Mercer, you'll find innovation reflected in our everyday culture. With our unique expertise and leverage, we ensure that the latest ideas are presented to our clients. We will work together with you to seize opportunities and guide your organization and people toward a better future.

➢ 3. No Transition Issues or Risks, and a History of Proven Value and Commitment

A change of professional advisors can bring about a lot of challenges to be considered, with many possible risks or unexpected pitfalls along the way. We have worked with you on a significant portion of the requested services, and staying with Mercer means:

- **Avoiding the risk of substantial consulting fee increases with a new advisor** that could occur through charges for a "new or out-of-scope" project that Mercer has done before; uncertain ultimate fees independent of quoted hourly rates with unknown efficiency, billing strictness, unwillingness to invest / partner, lack of staff resources to leverage, transition time and costs, and additional costs from conducting engagements without the benefit of previous strategy and project background and materials plus, you already know the typical fees produced by our hourly rates.
- **No loss of continuity with vendors** history, claim audit commitments and follow-up, data used in various audit and reform initiatives, existing confidentiality and consultant / vendor authorization, HIPAA and online data access and agreements.
- **Very importantly, elimination of transition time for your staff** at a time when your business operations may not have the extra benefit resources required to engage, monitor and manage a new consulting service provider.

Your partnership with Mercer ensures continued access to the highest level of expertise in the business. While you can trust Mercer's commitment to help you minimize risks during any

transition, by retaining Mercer you will continue to receive access to responsive urgent service timing, updates to prior analysis, and confidence that we will deliver what we promise.

Your Mercer Team

Mercer's size and scope allows us to bring the Customer a combination of personal service tailored to your needs supported by the power of national intellectual capital and resources. Your core Mercer team members are able to respond swiftly to your day-to-day needs and to meet with you in person on short notice, as needed.

The proposed team for the Customer comprises carefully chosen professionals with the experience (including government clients), technical expertise and tactical management skills needed to meet your goals and requirements. Most of our proposed team members noted have more than twenty years of experience, direct experience working with the Department, and understand the Department's benefit programs as well as the need for flexibility and responsiveness. Most proposed team members reside in our Atlanta (region specialty hub) or our Florida offices. The team will be supported by appropriate supporting technical and consulting staff from our national, regional and local specialty and general staff, as needed. With this depth of expertise, the Customer can be confident that Mercer will meet your dynamic and multi-faceted needs — both today and tomorrow.

Keith Hanson, your Client Relationship Manager and Strategic Advisor, and as a senior member of our healthcare practice, has the authority and ability to structure the team to meet your individual needs in all areas of the engagement, without organizational constraints. He will work hard to ensure your full satisfaction with our services and will be a central, overarching point of contact for any significant and/or escalated issues or questions that arise. He has experience working with organizations of the Customer's size and in your industry and will be sure to deploy the right resources at the right time. He will work closely with our core team members and specialists who will help you meet your needs and requirements in key areas.

A summary of proposed team members and their associated roles and experience are provided in the table that follows. Full biographies for all team members are available upon request.

TEAM MEMBER	ROLE/RESPONSIBILITY
Keith Hanson, CEBS Principal	**Client Relationship Manager and Strategic Advisor** Responsible for Mercer's overall relationship with the Customer, ensuring seamless service delivery, monitoring team performance, providing problem resolution and ensuring overall quality control
Robin Hagerty, FSA, MAAA Partner	**Executive Sponsor** Atlanta Health Practice Office Business Leader who ensures team members have access to the full breadth and depth of Mercer's resources to meet the Customer's needs

TEAM MEMBER	ROLE/RESPONSIBILITY
Matthew Snook Partner	**Florida Health Plans Advisor** Senior leader in our Florida market healthcare practice and can provide state and local insights on legislative, employer, vendor and market activity
Ben Rayburn, FSA, MAAA Principal	**Health Lead Actuary** Senior resource responsible for managing all actuarial requirements for Customer's projects
Alison Reynolds, ASA, MAAA Senior Associate	**Health Actuary** Provides financial modeling, reporting, and project management
Andy Hupfer, FSA, MAAA Senior Associate	**Health Actuary** Provides financial modeling, reporting and project managment
Valentino Rodrigo Analyst	**Financial Analyst** Assists with financial modeling and reporting
Joe Badalamenti, FSA Partner	**Health Consultant** Senior leader responsible for the delivery of health and benefits consulting services
Rosalind Britt Principal	**Health Consultant** Senior leader responsible for the delivery of health and benefits consulting services
Katelyn Mitchell Analyst	**Health Analyst** Under the guidance of lead and supporting consultants, executes all strategic decisions and serves as a day-to-day resource

As described in the Experience section, Mercer is well-suited to provide the services requested in the Actuarial Service Categories. The proposed team members for the Customer have the requisite skills and experience to deliver all items listed in the Scope of Work, including the Tasks outlined in Section 2.5.1 of the RFP.

PART 2: PROPOSED SOLUTION

As described earlier (please refer to the "your Mercer team" section in the Experience part of this document), Ben Rayburn will lead Mercer actuarial services projects for the Customer. Working together, Ben and Keith will develop strategy and determine the appropriate resources, including additional qualified team members to meet/exceed Customer's needs for each specific project.

General solutions include developing expected gross and net budgets from historical claims information, incorporating any changes in program design, demographics and other elements, which may have a material impact on results. More explicitly, Mercer uses actuarial lag triangles segregated by benefit program, along with historical enrollment, to develop incurred claims by program and month. A regression line is passed through the "adjusted" data by program to determine the unique claims trend associated with an employer's experience. Changes in program demographics are separately analyzed to determine whether or not the change in underlying or future demographics will impact or has impacted observed claims trends. "Adjusted" data means the claims data accounting for design, vendor, and other program changes that have impacted observed claims trends.

With respect to monitoring and adjusting budgets, Mercer generally monitors an employer's incurred claims and budget activity on a quarterly basis. This monitoring includes establishing the liability for self-insured program claims which have been incurred but not reported (IBNR). Additionally, we recommend reviewing open enrollment results to detect potential budget variations due to changing cost expectations from open enrollment.

When a deviation between budget and actual experience emerges, Mercer diagnoses program demographics, including the geographic dispersion of employees and how long employees have been employed, large claims changes, utilization changes, program design and vendor changes as well as the impact of elements like Health Care Reform, mental health parity, and any impact of the business environment.

In monitoring net costs, Mercer carefully monitors and projects both administrative fees and employee contributions.

Mercer's policy is to have all budgets and financial forecasts developed and reviewed by a minimum of two credentialed health care actuaries. Our process for developing and monitoring budgets was developed by our Actuarial and Financial Group, which oversees all actuarial and financial services provided by Mercer.

Claims Analysis

Claims analysis models are described below.

Client Experience Reporting Tool (CERT) — This model provides monthly, quarterly, semi-annual and/or annual financial reporting for self-funded plans. Output includes a series of dashboards and tables that report on plan enrollment and costs (paid claims, administrative costs and employee contributions) as compared to budget levels. Along with detailed month-by-month enrollment and cost exhibits that allow for reporting by plan, class and/or division/location, the model also provides high-level executive dashboards that illustrate plan performance in just a few pages.

Mercer FOCUS — Mercer FOCUS is our turn-key data warehouse offering, with measurement and analytics and consulting expertise. It allows clients to choose the option that best fits their specific needs:

- **Frame** — Structured insight leveraging carrier-based information
- **Snapshot** — A one-time data warehouse that fully integrates and allows for reporting on multiple medical and drug sources for a 90-day window
- **View** — Tailored to employers with less than 2,500 employees
- **360** — Fully integrated data warehouse solution that incorporates medical, pharmacy, disability and health management data from multiple data sources
- **Optimization** — A unique optimization solution for an employer's own data warehouse

Incurred-But-Not-Paid (IBNP) Valuation Model — We use the IBNP valuation model to value unpaid claims liabilities. The model estimates a client's IBNP liability at a given valuation date and can also project that liability to a later date (if needed). While providing a fair amount of flexibility in setting assumptions, the IBNP valuation model ensures that our consulting actuaries use a consistent platform for calculations and consider all of the IBNP liability components below:

Incurred-But-Not-Reported (IBNR) Claims Liability: The liability for claims that have been incurred, but not reported. Historical claims payment patterns (as exhibited in claims lag triangles) are extrapolated and adjusted for seasonality and trend to estimate ultimate incurred claims.

Claims Issued But Not Cleared the Bank: The liability attributable to the lag between the time a carrier reports payment in a claims lag triangle, and the time the payment actually clears the client's bank account.

Margin: This is an explicit margin in liability estimates

Liability for Runout Expenses: This component quantifies the costs for administrative fees to process claims paid after plan termination, if required by the administrator's contract.

Ongoing Review of Plan Performance

As a supplement to insurer/vendor reporting packages, Mercer provides ongoing review of plan performance. We use our proprietary software and surveys to assess plan performance metrics and statistics. Services in this area include:

- Tracking and analyzing monthly experience for self-funded coverages relative to budget projections and providing quarterly trends
- Evaluating claim utilization data to spot areas of over-utilization and recommending strategic plan changes that promote desired behavior
- Reviewing large claims experience and the impact on cost trends
- Identifying and analyzing trends affecting your plans

- Calculating funding requirements for current and upcoming plan years, including development of premium equivalents for budgeting purposes and COBRA premium rates
- Analyzing incurred-but-not-reported (IBNR) claims for self-funded plans

Once funding requirements are determined for the next plan year, we will work with Client to establish employee contributions by tier level for each enrollment option.

Monitoring Plan Financial Performance

Given the expense associated with employer sponsored health care, Mercer appreciates the need to closely monitor the financial performance of your plans. We will work with you to identify all information that we would require for ongoing review. We will also develop a reporting package that provides a "dashboard" and all necessary supporting data from our analysis and addresses all of your needs at the appropriate level of detail and frequency.

Generally, we provide our CERT monthly claim tracking reports. These reports detail monthly enrollment, premiums, fees and paid claims by coverage and are the basis for quarterly trend analysis and renewal projections and strategy discussions. These reports also compare actual costs to the budgeted renewal projections, particularly for plans that are either self-funded or minimum premium. We also will track high-claim activity on a regular basis.

For self-funded and minimum premium plans, all or most of the data is usually readily available. Employers with experience-rated plans that are fully insured often receive some level of data from the insurer, but typically not everything needed for proactive plan management, and plans that are based largely on book or community rating (for example, HMOs or small groups) are not usually provided any data at all.

In addition, CERT provides a monthly "dashboard" that captures the most relevant and informative measures and indicators to streamline the analysis for executive review. We will work closely with your vendors to make sure we have access to all of the data required to support your reporting needs.

Cost Projections

On an annual basis (or upon request), Mercer will provide budgeting, forecasting and renewal projections for the Customer's medical, dental and vision plans. For self-funded plans, we provide projections for incurred claims, stop loss premium (if applicable), administrative fees and other applicable fixed costs. For fully insured plans for which adequate claims experience is available, we perform independent renewal projections to verify the appropriateness of an insurer's fully insured renewal calculation. This process starts by developing projections for the upcoming year based upon a status quo plan design situation, which we would augment by any known program changes for the upcoming plan year. In addition to these elements, we will present market trends and the Customer-specific opportunities derived from your utilization information and strategies.

The cost projection process includes eight key steps:

1. **Data collection and review.** Claims and enrollment data may be generated by the Customer via your data manager (or we can request it directly from your vendors). A full understanding of the data is required to ensure the accuracy of our projections.
2. **Development of trend rate and other key assumptions.** Annual trend rate — the expected percentage increase in per capita costs — is the primary assumption used in our cost projections. We update internal trend guidelines twice per year based on market data from Mercer's large client data sets, results of carrier surveys and feedback from our experts on future expectations within various categories. These internal trend guidelines, along with the Customer-specific utilization data, provide the resources needed to set future trend assumption. Other projection assumptions, such as claim lag adjustment from paid to incurred basis, administrative fee changes and margin are also established at this time.
3. **Underwriting.** Using underwriting techniques based on actuarial guidelines, we project future plan costs. The key factor in projecting future results is the prior claims experience of a group, especially when the group consists of a large population. The process of forecasting past claims experience into the future takes into account plan designs, member demographics, trends and group credibility.
4. **Impact of Migration and Selection.** When multiple plan options are offered and migration is expected, the impact of participant selection risk (migration of low risk persons to low plans or vice versa) is considered and appropriate rate adjustments are made.
5. **Valuation of plan design changes.** We use our proprietary tools to estimate the impact of any future changes in design; this is followed by an actuarial review for reasonableness.
6. **Valuation of other plan interventions.** This could include health management programs (such as disease management), and will involve coordination with the team members designing and negotiating these programs; the valuation of the intervention will undergo an actuarial review for reasonableness.
7. **Calculation of tier values.** This is the actuarial valuation of the differences in cost between the dependent coverage levels offered by the Customer. This requires evaluation of risk by dependent relationship type and coverage type.
8. **Estimate combined impact of plan design and contributions policy.** This step estimates the potential impact of enrollment shifts among the plan choices available for a given set of plan choices and required contributions. An ongoing strategy regarding employee plans and contribution rates would typically be a component of the overall State of Florida budget, benefits and compensation strategy. The strategy would likely be a function of numerous key input areas, starting with a general methodology regarding cost sharing, impacted by dynamic factors including business cost pressures, employee morale, competitive positioning, historical actions in the areas of contributions

and plan changes, bargaining unit contracts and/or pressures, merger and acquisition activities, prevailing trend rates and others.

Incurred-but-not-Reported (IBNR) Calculations

In estimating the IBNR for medical, prescription drug and dental benefits, we use the claims loss development method. This method uses previous patterns of payments (number of months from incurred month to paid month) in the adjusted historical lag data to estimate incurred claims from those paid to date. For the most recent one or two months, the initial incurred claim estimates that are produced by the development method may vary considerably. In such cases, an expected value (based on prior months' costs trended forward with further adjustment for seasonality if appropriate) is blended with the initial incurred amount from the development method.

Mercer's IBNR Liabilities Standard includes additional items for consideration in IBNR analysis including:

- Terminal runout claim administration
- Estimated claims issued but not cleared the bank
- Imprest balance
- Pending stop loss reimbursements
- Prescription drug rebates receivable
- Claims fluctuation margin

Mercer will review the IBNR calculations with the Customer and address any questions. Our report will include, at a minimum, the reserve amount by plan and product as well as all assumptions used to develop the calculations.

Benefit Cost Drivers

Reviewing historical plan experience and trend on a regular basis is an important part of supporting the Customer's strategic and plan management needs. Working closely with you, Mercer will identify the appropriate timing and analyses, building a plan management dashboard as well as noting questions and challenges at hand.

In our review of the Customer's claims experience and utilization metrics, we will identify any problem areas and place claim experience into a context from which we can help evaluate current program strategies. We will also develop measurement metrics based on the Customer's program goals. These can be limited to plan design financial metrics (utilization and unit cost by place of service (for example, Emergency Room) or service category (for example, brand name drugs, durable medical equipment) or can address overall population health risk or program performance. A typical area for evaluation would be to measure the level of discretionary healthcare utilization. The initial review can also involve assessing the level of plan cost by various disease groups. This benchmarking can serve as a valuable baseline in the assessment of the Customer's disease management and/or health enhancement strategy.

For future cost projection purposes, Mercer's AFG releases expected future trend tables and guidelines twice per year that reflect standard trends from an underwriting perspective. The trend guidelines are established based on observations in the market from Mercer's large client data sets, carrier survey responses, and feedback from our experts in various specialty practice areas.

Contribution Rate Setting

Employee contribution rate setting is a fluid process that influences the plan that an employee chooses and, ultimately, the aggregate and net total cost of coverage.

The process typically includes the following steps:

- General conversations with the Customer regarding any key employer and employee cost targets
- Discussion of strategic alternatives that address employer goals/targets, and preliminary agreement on those which need to be explored and evaluated (for example, constant subsidy percentage, core buy-up subsidy, consumerist incentives, how plan design changes will impact contribution strategy, etc.)
- Preliminary calculations and cost projections evaluating the impact of baseline (status quo) and alternative scenarios, reflecting not only the impact on participant contribution, sponsor contribution and rates of increase, but also on overall plan participation and movement between options and coverage tiers
- Review of all preliminary calculations, with additional iterations, as needed

Employee Contributions Considerations

Considerations for setting employee contributions (this applies largely to medical and dental, but could apply to other coverages as well) include:

- Competitive position in industry, which should be balanced with the competitive position of other plan cost-sharing components
- Historical positioning of the company, including employee expectations, such as targeting 80% of some benchmark (industry, region, etc.)
- Equity, which can have different definitions, such as asking employees to pay more if they earn more, if they represent a greater health risk (where permitted), if they cover more dependents or if they have coverage available elsewhere
- Net cost target for employer spending
- Employee affordability — perhaps looked at as a maximum percent of pay or to comply with PPACA requirements
- Steerage with multiple options to encourage integration and consumerism while managing selection
- Philosophy of pay-to-access (higher contributions, richer plan design) versus pay-to-use (lower contributions to access, more out-of-pocket cost to use)

- Philosophy of subsidizing dependents ("family friendly" versus the view that the company's primary responsibility is for the employee and not for dependents)
- Administrative simplicity, such as issues about administering pay-based scales or spousal surcharges, which can make these options impractical to administer

As contributions are determined each year, we can work through any, and all, of these considerations to determine a context for setting and communicating contributions that best meet the Customer's business needs.

Alternative Employee Contribution Strategies

There are several employee contribution strategies that employers use in the financing of their health programs. The best strategies are those that drive desired behavior, through a structure that is easy to communicate and administer. Some of the more typical strategies include:

- Same percentage subsidy: for example, employee pays 25% of cost of plan elected.
- Same dollar subsidy: for example, employer pays $150 per month towards cost of plan elected.
- Subsidy based on coverage tier: for example, employee pays 25% of the plan cost for Employee Only coverage and 35% of the cost for Family coverage.
- Subsidy based on pay: for example, employee pays 20% of the plan cost for employees earning $25,000 or less; 25% of the plan cost for employees earning between $25,001 and $50,000; and 30% of the plan cost for employees earning $50,001 or more.
- Subsidy based on a "core" plan: for example, employee pays 20% of the plan cost for a core plan. Employees pay the core plan contribution plus the difference in cost between the core plan and the other choices (which could be more or less expensive).
- Subsidy based on participation in a wellness program or exhibiting healthy behaviors: for example, the employee would pay a higher contribution if they are tobacco users than for non-tobacco users.
- A same dollar subsidy or a subsidy based on a core plan are in essence "defined contribution" approaches that allow employers to lock in their costs and can effectively be used in a health benefits management platform such as **Mercer Marketplace 365+**.

All of these strategies can be tailored to produce a desired net financial result. The strategy ultimately employed is more dependent on the organization's ability to administer the program

LEGISLATIVE AND REGULATORY SUPPORT

Mercer understands the time sensitivity the Customer faces when needing legislative support. We are able to accommodate your needs when asked to review proposed legislation and determine potential program impacts. We have a track record of experience working with the Department and are able to interpret financial and other impacts to the Department's employee benefit plan. We staff our projects with actuaries and others with experience working with large, government employers. Our actuaries have experience preparing fiscal impact notes and bill analyses; given our extensive actuarial and other resources, we are able to be flexible and responsive, allowing us to respond to requests in a timely manner.

We have two groups of legal professionals that track legislative, regulatory, judicial and policy activity related to employer-sponsored health and welfare plans. These groups work proactively to keep our consultants and clients informed of such activity and develop practical strategies for employer-plan sponsors to comply with new developments in the laws, regulations and sub-regulatory guidance impacting their health and welfare plans.

Regulatory Resources Group (RRG) — With approximately 25 lawyers and regulatory compliance specialists, Mercer's RRG staff are imbedded in the local office consulting teams to deliver technical and regulatory compliance support, tools and services to make sure your health and welfare plan designs, operations, and transactions comply with applicable laws and regulations from a practical, risk management perspective. We have assigned Terry Dailey as a member of the Customer team.

Law & Policy (L&P) Group — L&P is a team of lawyers, actuaries and technical experts who analyze health, wealth and global legislative, regulatory, judicial and government relations issues. We have the insight, relationships and experience to provide expert analyses on a variety of US, state and global compliance and policy matters. We develop leading-edge intellectual capital — like GRISTs and the monthly Global Legislative Update — valued by Mercer consultants and clients alike. Our collaborative process enables us to provide concise and "reader-friendly" articles that highlight relevant information, analyze legal issues and give specific action steps or considerations. L&P partners internally across Mercer's lines of business to help clients address their most complex issues. In the US, we specialize in federal and state benefit and leave laws, including relevant tax, actuarial and accounting issues. Our US coverage focuses on health and welfare plans for active and retired employees, including all aspects of the ACA.

TOOLS AND RESOURCES

Our processes, tools and methodology were designed — and are constantly refined — by actuaries and financial analysts in our national **AFG**, described earlier.

Our top priority is to help you improve the well-being of your organization and the lives of your employees through actions you take today. To make smart decisions, you need relevant data and analysis that lets you see the whole picture. We provide these insights through our full range of health and benefits tools, including modeling and valuation tools, surveys, data warehouses, benchmarking studies, information portals and databases. The following represents some of those proprietary tools we may use through our partnership.

Life, Absence and Disability (LAD) Models:

Long Term Disability (LTD) Tool. Calculates the liabilities and annual cash flows associated with employers' long-term disability benefits, including income replacement and health and benefits.

LTD Rating Tool. An underwriting tool used to calculate self-funded LTD premiums for large employers.

Absence Management Analytic Tool (AMAT). Helps employers understand their current plans costs, competitiveness, compliance and financial liability.

ASO Fee Benchmarking Tool. Benchmarks administrative service only (ASO) fees relative to employers with a similar basket of services. This robust database provides benchmark data for more than 1,000 organizations across the US and includes data on base ASO fees, as well as fees for utilization review, pharmacy, banking, nurse line, behavioral health, dental, vision and many other common administrative fees.

Benefit Valuation Analysis. Measures the value your benefit plans bring to your employees, while assessing the competitiveness of your benefit package to those of peers by plan groupings (that is, Retirement/Savings, Health/Group and Time Loss), and by individual plans.

Consumer Driven Health Plan (CDHP) Pricing Model. Provides multi-year, multi-option financial projections, including gross, employer and employee costs, building on results from our MedPrice model and the Standard Mercer Rating Tool.

Client Experience Reporting Tool (CERT). A financial tracking tool developed for self-funded clients, it provides a comprehensive overview of plan (medical/Rx, dental, vision) performance in various key areas, enabling us to track plan performance on a monthly, quarterly and semi-annual/annual basis.

Claims Risk and Fluctuation Tool (CRAFT). Measures variability of health plan costs, simulates your annual health claims spend, illustrates the variability of annual claims, provides a suggested claims fluctuation margin for budgeting, and performs self-funding versus insuring analysis.

DXCG Risk Assessment Tools. Uses medical and/or pharmacy data to predict future resource use and evaluate historical performance.

GBM Client Delivery Portal. Enables us to store information and share content with you for global benefits management, including project management tools, executive dashboards, an activity tracker dashboard, reference materials and survey reports, global updates and news feeds.

Health Care Cost Wizard. Combines results of our annual *National Survey of Employer-Sponsored Health Plans* and client-specific goals to create custom healthcare cost benchmarks.

Health Care Reform Models/Tools. Quantifies the financial impact of healthcare reform, including fees, 2022 Excise Tax Projections, Grandfathered Health Plan Cost-Sharing and various measurement and pricing strategies.

HERO Employee Health Management (EHM) Best Practices Scorecard in Collaboration with Mercer ©. Shows you opportunities to improve your health management programs by modeling best practices. An international version is available.

HIPAA Tools. Designed by Mercer's Law & Policy (L&P) group to assist clients' group health plans comply with the HIPAA privacy and security rules. They include:

The **HIPAA Privacy Manual** tool, which helps clients fulfill the policy and procedure requirements of the HIPAA privacy rules.

HIPAA Security Manual and **HIPAA Security Assessment (SAFE)**, which help clients fulfill the requirements of the HIPAA security rules.

MarketScan® Employer Norms Tool. Utilization and financial norms produced from Truven Health Analytics client databases. Information reflects the health care experience of employees and dependents covered by the health benefit programs of large employers. Data is collected from approximately 100 insurance companies, Blue Cross Blue Shield plans, and third-party administrators.

MedPrice. Accesses a national database of more than $5.7 billion in covered claims data from our clients, developing relative values by re-pricing claims based on underlying data and specific plan designs.

Mental Health Parity Models. Designed to assist in quantitative testing and analysis for Mental Health Parity compliance.

Mercer BenefitsMonitor™. Provides online access to plan features of traditional retirement, health and group, time-off plans and car policies in Asia, Pacific and Africa. It compares your benefits data against that of competitors and the general market, helps you analyze benefits plans for various employee groups and provides a one-stop source for the latest statutory benefits information.

Mercer FOCUS. Links claims and demographic data through a data warehouse and decision-support system, giving you a complete view of healthcare cost drivers and other critical metrics, with up to three years of history and monthly updating available.

National Survey of Employer-Sponsored Health Plans. Gathers information annually on employer health plan-related issues — including costs, strategic planning, plan provisions, and scope and limitations of coverage — so you can benchmark your benefits with your peers.

Network Provider Contracting Analysis (NetPiC) Dental. Helps us evaluate provider contracts with the major carriers, in specific regions and across the US, on a normalized basis — with a disruption analysis to compare network use across vendors.

Network Provider Contracting Analysis (NetPiC) Medical. Presents negotiated health plan provider fees on a comparable basis, by analyzing fee arrangements between providers and the largest US health plan vendors.

Retiree Drug Subsidy (RDS) Attestation Model. Used to calculate whether your prescription drug benefits are at least actuarially equivalent with the benefits provided by Medicare Part D.

Rx Pricer. Projects the costs of self-insured pharmacy plans in comparison with your current financial arrangement, based on your specific claims experience data.

Seasonality Model Tool. Provides a mechanism to estimate seasonal patterns of incurred and paid claims and calculates seasonality factors unique to the specified plan design.

Standard Mercer Rating Tool Enhanced Rating (SMRTer). Supports the budgeting and renewal process for both self-funded and fully insured health plans by evaluating and projecting health plan costs.

Stop Loss Pricing Model. Provides one data point for a client regarding potential large claim activity and the cost associated with stop loss coverage.

Survey on Absence and Disability Management. Demonstrates employer initiatives that have reduced costs and improved administrative efficiency through strategies for incidental absence and disability management, vacation plans, paid time-off banks, sick leave plans and disability benefits.

Total Remuneration Index. The most complete and comprehensive report that expands on benefits benchmarking reports by factoring in salary — determining a Total Reward Value for jobs by combining the effect of the differences in both pay and benefit design; helps you see how all the pieces fit together and if changes are needed.

Trend Guidance Tool. Tables provide guidance for projections of cost trends for medical, dental and prescription drug benefits as well as the associated administrative costs for employer-sponsored health plans. Cost trends are discussed primarily as changes in costs per exposure unit over a range of exposure periods. These same cost trend guidelines also address the initial trend rates for retirees as accounted for under ASC 715 (previously SFAS 106).

Value-Based Care Market Profiles/Analysis. Includes actionable data from our most recent proprietary value-based care RFI covering 149 markets and 634 VBC systems; helps determine the extent of the opportunity for cost savings, improved quality and a better patient experience. It allows you to quickly and easily identify the markets where value-based care offers the greatest potential and help evaluate how well individual providers in each market are able to deliver value-based care.

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TECHNICAL PROPOSAL (ATTACHMENT D)
SERVICE CATEGORY 3 – CLAIMS AUDITING

REQUEST FOR PROPOSALS - NO. 19-801111502

As required by the RFP, Mercer's Technical Proposal contains two parts and are submitted separately for each Service Category:

- **Experience:** focuses on Mercer's capabilities in the Service Category and the qualifications of the specific team members who will deliver the services to the Customer.
- **Proposed Solution:** describes our processes and approach for delivering the requested services in the Service Category.

PART 1: EXPERIENCE

Mercer has been providing health and benefits services for more than 80 years. Our US Health business comprises nearly 2,500 employees, and serves almost 4,000 clients. With one of the largest groups of seasoned experts with knowledge and experience spanning every aspect of healthcare, Mercer is well-positioned to provide all of the services requested in each of the three Service Categories: Benefits Consulting, Actuarial and Claims Auditing. A general description of our firm's capabilities in addition to those in the Claims Auditing Service Category is provided below, along with information about the core team members who will provide the services to the Customer (as reflected in the RFP we have used the general term "Customer" throughout our proposal to reflect all state agencies and eligible users for this Contract).

Mercer believes there are three (3) primary reasons that we are uniquely capable of assisting in achieving your goals and objectives:

- We know your industry/state governments, your program, vendors, the market, and you/Customer
- We Bring Unequaled Expertise, Capabilities, and Approach
- No Transition Issues or Risks, and a History of Proven Value and Commitment

➢ 1. We know your industry/state governments, your program, vendors, market, and you/Customer

Knowing Your Plans, Vendors and History, Uniquely Qualifies Us to Meet Your Needs

Over the years, Mercer has worked with you to ensure delivery of effective strategies and solutions. We have helped you define your principles, key issues and strategic priorities. We have shown we can work quickly with you to identify, craft, and validate new solutions to meet your current and future needs. We pride ourselves on delivering high-quality advice; services and solutions that have helped the State of Florida facilitate discussions and produce results.

Your Mercer team knows you and your history, allowing us to effectively revise or leverage prior work with minimal cost and transition time. In the past few years, we have provided support to the State of Florida including the following initiatives:

- **Pharmacy performance and operational audits**
- Numerous actuarial modeling projects, including pricing, review, and analysis of alternative designs and contributions, and impact to overall budget
- Medical plan analysis and procurement consulting
- Pharmacy plan analysis, renewal negotiation guidance, and PBM procurement consulting
- Benchmarking (our survey resources are well known and considered the "gold standard" in the industry
- Healthcare reform actuarial modeling
- HMO plan referral pattern analysis (in depth data analytics project) and actuarial modeling
- Compliance support (Mental Health Parity review)
- Persona cluster analysis
- MAPD consulting
- Legislative support

As we look ahead, Mercer is uniquely positioned to help you both ***cost-effectively*** apply those strategies and tactics previously identified as valid and ***quickly take a fresh look*** for building new ideas that enhance your benefit and total rewards programs.

➢ 2. We Bring Unequaled Expertise, Capabilities, and Approach

OVERVIEW: CLAIMS AUDITING CAPABILITIES

Mercer's **Performance Audit Group (PAG)** is an independent, stand-alone, practice. Our consultants are not auditors and vice versa. We have conducted administrator audits since the mid-1980s and leverage the expertise of 28 colleagues — with an average of 19 years of experience in the health claims auditing industry — dedicated to administrator performance management. Over the past five years, we have audited dozens of administrators for more than 500 employers. During this same period, we have identified ***tens of millions of dollars in financial overpayments*** on behalf of said employers.

With capabilities to perform both claims and operational reviews, Mercer's performance audits can focus on any type health plan and funding arrangement (such as, self-funded or insured plans; HMO, POS, PPO, or EPO plans; and medical, pharmacy, behavioral health, dental, or vision plans). In addition, we can also provide auditing assistance with the administrator shared savings programs.

Our approach begins with determining a client's needs and objectives and then developing an audit plan to meet these goals. We request necessary information, perform the audit at the administrator's claims processing facility or electronically, evaluate the results, and prepare and present a written report of our findings, conclusions and recommendations. An audit typically takes 18-22 weeks from the date we receive data for claims sampling to delivery of the final audit report.

Audits are an excellent tool to monitor and evaluate health plan administrator performance and to identify opportunities to help lower our clients' costs. Moreover, our audit results provide powerful and quantifiable information that can be used for:

- Renewal negotiations
- Root cause error trend analysis
- Discovering and developing remedies for customer service problems

The end results provide an improved level of services to plan members and their families.

Our audits evaluate performance in comparison to common and best practice industry standards, and may help to establish or enhance performance guarantees with an administrator to increase its accountability for providing high-quality and timely claims administration services. As part of our audit, we provide action plans to help the administrator implement our recommendations, and we create expectations for improvement and how that improvement will be quantified and realized by the employer in the form of increased efficiencies and claim cost savings. ***Mercer audits typically pay for themselves with an average ROI savings of at least 5:1 over time***. Our expected savings are best expressed in this context as a combination of direct (immediate) and indirect (future) savings through improved procedures and controls.

We highly recommend that plan sponsors periodically audit their health plan administrators. Specific benefits of performing audits include:

- Verifying program compliance and application of network provider/pharmacy rates
- Assurance that plan dollars are being spent accurately
- Measuring performance and evaluating against "best practice" standards and benchmarks
- Increasing administrator accountability to ensure high-quality and timely service
- Identifying the root causes of problems and opportunities for operational and claims processing improvements that can maximize performance, lower costs and enable service improvements
- Satisfying internal audit requirements and plan fiduciary obligations

Audits can also provide added leverage for renewal and performance guarantee negotiations and can result in immediate, as well as long-term savings.

Mercer Advantage

When it comes to health and benefits advisory services, we know that you have many options from which to choose. Why do so many clients choose Mercer over other consulting partners? Because as organizations grow and increase in complexity, Mercer is unmatched in providing the support necessary to help optimize your success.

Best of Both Worlds

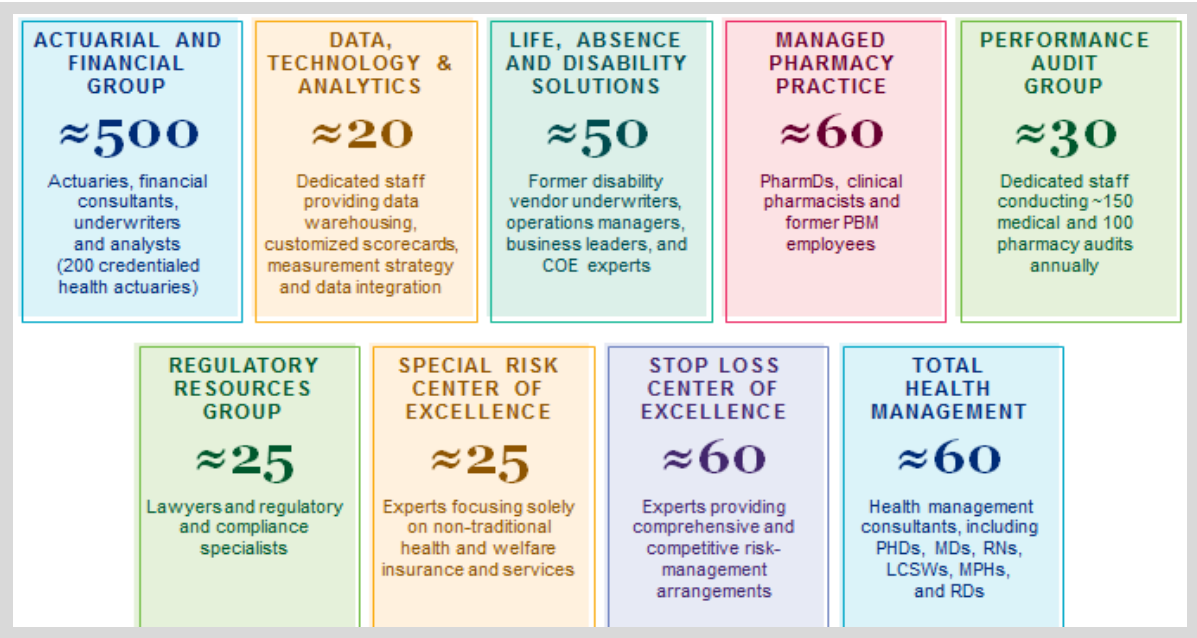
Healthcare strategy is at the heart of our business. Our experts span every aspect of healthcare — general HR strategy, consumerism and wellness, finance and actuarial science, clinical and

health management, pharmacy, operations and more. We monitor the benefits landscape, the impact of evolving compliance requirements and individuals' evolving needs. By offering innovative health benefit strategies and alternatives, we keep our clients at the forefront of any changes. This includes developing new client strategies that address evolving health reform requirements.

The commitment, experience and proactivity of our team is enhanced by the expertise, intellectual capital and thought leadership of Mercer's expansive **national organization**. Together, these are powerful strengths that deliver big results for our clients in every segment of the marketplace.

Deep Bench

To help our clients achieve their benefits goals, Mercer's Health consultants are supported by a deep bench of subject matter experts in the following areas, some of which are discussed later in our response:



With these resources, we'll help you develop a thoughtful, relevant benefits strategy for your toughest challenges. You can breathe easy with the assurance that you're accessing what your workforce needs today, along with innovations that keep you competitive and help you stay ahead.

Mercer Muscle

Our position as one of the world's largest benefits brokerage/consulting firms gives us a **leading market share** with nearly every major group carrier and national administrator. This gives the Customer unparalleled access to, and leverage in, the benefits market — enabling you to reap maximum value from the premium dollars you invest in your plans. Our team will tap into Mercer's **Carrier Relations group**, which leads several programs to maximize vendor engagement.

Innovation That Fits

When you work with Mercer, you'll find innovation reflected in our everyday culture. With our unique expertise and leverage, we ensure that the latest ideas are presented to our clients. We will work together with you to seize opportunities and guide your organization and people toward a better future.

➢ 3. No Transition Issues or Risks, and a History of Proven Value and Commitment

A change of professional advisors can bring about a lot of challenges to be considered, with many possible risks or unexpected pitfalls along the way. We have worked with you on a significant portion of the requested services, and staying with Mercer means:

- **Avoiding the risk of substantial consulting fee increases with a new advisor** that could occur through charges for a "new or out-of-scope" project that Mercer has done before; uncertain ultimate fees independent of quoted hourly rates with unknown efficiency, billing strictness, unwillingness to invest / partner, lack of staff resources to leverage, transition time and costs, and additional costs from conducting engagements without the benefit of previous strategy and project background and materials plus, you already know the typical fees produced by our hourly rates.
- **No loss of continuity with vendors** history, claim audit commitments and follow-up, data used in various audit and reform initiatives, existing confidentiality and consultant / vendor authorization, HIPAA and online data access and agreements.
- **Very importantly, elimination of transition time for your staff** at a time when your business operations may not have the extra benefit resources required to engage, monitor and manage a new consulting service provider.

Your partnership with Mercer ensures continued access to the highest level of expertise in the business. While you can trust Mercer's commitment to help you minimize risks during any transition, by retaining Mercer you will continue to receive access to responsive urgent service timing, updates to prior analysis, and confidence that we will deliver what we promise.

Your Mercer Team

Mercer's size and scope allows us to bring the Customer a combination of personal service tailored to your needs supported by the power of national intellectual capital and resources. Your core Mercer team members are able to respond swiftly to your day-to-day needs and to meet with you in person on short notice, as needed.

The proposed core team for the Customer comprises carefully chosen professionals with the experience (including government clients), technical expertise and tactical management skills needed to meet your goals and requirements. Most of our proposed team members noted have more than twenty years of experience, direct experience working with the Department, and understand the Department's benefit programs as well as the need for flexibility and

responsiveness. Most proposed team members reside in our Atlanta (region specialty hub) or our Florida offices. The team will be supported by appropriate supporting technical and consulting staff from our national, regional and local specialty and general staff, as needed. With this depth of expertise, the Customer can be confident that Mercer will meet your dynamic and multi-faceted needs — both today and tomorrow.

Keith Hanson, your Client Relationship Manager and Strategic Advisor, and as a senior member of our healthcare practice, has the authority and ability to structure the team to meet your individual needs in all areas of the engagement, without organizational constraints. He will work hard to ensure your full satisfaction with our services and will be a central, overarching point of contact for any significant and/or escalated issues or questions that arise. He has experience working with organizations of the Customer's size and in your industry and will be sure to deploy the right resources at the right time. He will work closely with our core team members and specialists who will help you meet your needs and requirements in key areas.

A summary of proposed core team members and their associated roles and experience are provided in the table that follows. Full biographies for all team members are available upon request.

TEAM MEMBER	ROLE/RESPONSIBILITY
Keith Hanson, CEBS Principal	**Client Relationship Manager and Strategic Advisor** Responsible for Mercer's overall relationship with the Customer, ensuring seamless service delivery, monitoring team performance, providing problem resolution and ensuring overall quality control
Robin Hagerty, FSA, MAAA Partner	**Executive Sponsor** Atlanta Health Practice Office Business Leader who ensures team members have access to the full breadth and depth of Mercer's resources to meet the Customer's needs
Katelyn Mitchell Analyst	**Health Analyst** Under the guidance of lead and supporting consultants, executes all strategic decisions and serves as a day-to-day resource
Lisa Oswald Partner	**Audit Lead** Provide oversight into material development, conduct evaluations and co-develop report finding and recommendations
Shaena Friedman Senior Associate	**Audit Project Manager** Assist with the overall management of the audits project as well as conduct the rebate and operational audits

As described in the Experience section, Mercer is well-suited to provide the services requested in the Claims Audit Service Category. The proposed team members for the

Customer have the requisite skills and experience to deliver all items listed in the Scope of Work, including the Tasks outlined in Section 2.5.1 of the RFP.

PART 2: PROPOSED SOLUTION

As described earlier (please refer to the "your Mercer team" section in the Experience part of this document), Lisa Oswald will lead Mercer claims auditing services projects for the Customer. Working together, Lisa and Keith will develop strategy and determine the appropriate resources, including additional qualified team members to meet/exceed Customer's needs for each specific project.

Audits are a valuable tool for evaluating a Vendors' performance, identifying cost savings opportunities, ensuring compliance with relevant regulations, statutory requirements, and with contract terms and plan provisions, assessing the accuracy of processes, and improving administrative efficiency. At Mercer, we use audit findings to facilitate strategic action plans with our clients. When we perform an audit, we leverage the results to recommend follow-up actions that support the goals and objectives of your overall benefits program. We are well-positioned to play this strategic role for the Customer, based on the following:

- **We can leverage our knowledge of the Customer's Vendors to your advantage –** Mercer has conducted many medical and pharmacy benefit audits over the years for the Customer. During the last five years, relative to the Customer's pharmacy program, we have ***identified millions of dollars*** in erroneous payment errors. In recent years, we have conducted the following audits on behalf of the Customer:
  - Medical and pharmacy claims
  - Pharmacy rebate
  - Operational assessment
  - Customer service assessment and call evaluation
  - Invoice validation
  - Eligibility verification
  - Medicare Part B coordination of benefits
  - Implementation review

- **We have long-term audit experience with the Customer's Vendors –** The Performance Audit Group conducts over ***300 medical and pharmacy audits annually***, which enables us to maintain a database of industry best practices for employer coverage of services and health plan administration and application of policy.

- **We bring team of experts with deep audit and benefits experience –** Mercer's Performance Audit Group is an independent, stand-alone, practice. Our consultants are not auditors and vice versa. We have conducted administrator audits since the mid-1980s and leverage the expertise of 28 colleagues - ***with an average of 19 years' experience in the health claims auditing*** industry - dedicated to administrator performance management. Over the past five years, we have ***audited dozens of***

administrators for more than 500 employers. During this same period, we have identified tens of millions of dollars in financial overpayments on behalf of said employers.

OUR APPROACH

Our approach begins with confirming the customer's needs and objectives, then developing an audit plan to meet the customer's goals. Our next steps for an audit would be to request needed information to conduct the audit, perform the audit, evaluate the results, and prepare and present a written report of our findings, conclusions and recommendations. We describe below the phases of typical claims audit projects.

Phase 1 – Planning

Mercer and the Customer meet to confirm the following:

- Objectives and scope of the projects
- Data requirements
- Timing
- Roles and responsibilities
- Next steps

Mercer will prepare a statement of work for the Customer's review and approval, confirming the scope, timing, and team for the projects.

Phase 2 – Pre-audit Preparation

Mercer initiates the audit process, including the following:

- We hold a teleconference kickoff call with Vendors to review project objectives, scope, methodology, work plan, and timeline.

- Next, we send a data request to the Vendors for claim history data for the audit period.
- Finally, we gather materials essential to conduct the audit (e.g., summary plan descriptions, Vendors' contract, performance guarantees, financial reports for balancing with the Vendors' claims data file).

Phase 3 – Analysis and Reporting

Mercer analyzes the results of the audit and prepares a draft report. We provide the draft report to Vendors for review and comments before it is finalized to ensure that we present a clear and accurate understanding of the issues.

Phase 4 – Report Presentation

Mercer prepares the final audit report to distribute to the Customer and Vendor. We will meet with the Customer to review the audit report and discuss recommended next steps and improvement action strategy.

Phase 5 – Implementation

Mercer is available to assist the Customer to the degree necessary in the development of its action strategy, and to facilitate a meeting with Vendors to discuss audit results and agree upon the Vendors' improvement action plan in response to the audit recommendations. The scope of work during this phase will depend on the Customer's needs and objectives in Phases 1-4 outlined above.

SCOPE, METHODOLOGY, AND TIMING

Pharmacy Claims

In an industry where a PBM audit is generally conducted on 100% of the claims, the ability to eliminate false positive claims and identify true errors, trends and financial contractual accuracy is what makes Mercer the best at what we do. Our process employs rigorous data collection and understanding of said data during the discovery phase of the audit. We spend a significant amount of time clearly defining contractual terms, including definitions and exclusions/limitations, and plan design parameters prior to programming our software. The results of our audits demonstrate that the outcome is substantially free of false positive errors. When false positive claims are eliminated, only true errors or exceptions remain. This is of significant value to employers that do not have the time or resources to chase errors with a PBM.

We will conduct an electronic review of 100% of the retail, mail order, and specialty drug pharmacy claims incurred during the audit period (we recommend the most recent

Mercer subscribes to Medi-Span, which is the national drug pricing compendium used for the determination of Average Wholesale Price (AWP). We will independently re-price each claim using Medi-Span rather than relying on PBM's self-reported ingredient costs. This audit will measure on an individual and aggregate claim basis whether the financial terms of the contract were met during the audit period.

calendar/plan year). Each claim will be reviewed from a financial and benefits perspective. Screening will be performed to verify the following:

Contractual financial obligations were met:

- Contracted ingredient costs/discounts were accurately applied, based on the published pricing for the date of service (including specialty drugs).
- Dispensing fees were correctly applied (including specialty drugs).

PBM was accurately administering the Customer's plan design and benefit parameters, in the following benefit categories:

- No evidence of duplicate claim payments
- Refill-too-soon threshold and overrides were handled accurately
- Non-covered drugs were appropriately denied or payments properly documented
- Drugs requiring prior authorization were correctly administered and documented properly
- Member cost share was accurately applied, such as:
  - copayment / coinsurance
  - deductible and out-of-pocket amounts
  - generics preferred program
  - retail refill restrictions
- Specific days supply limits were correctly applied
- Quantity limitations were correctly applied
- Confirmation that a sample of 50 DSGI members were eligible on the date of service

Mercer will review exception reports produced from the electronic audit. A representative sample of each issue will be provided to PBM for its review and research. Mercer will review PBM's responses to the audit representative samples and determine if the response satisfactorily addresses the audit issues or if additional research and documentation is required. A detailed audit report will be provided, including specific findings, recommendations and conclusions.

Pharmacy Rebate

Mercer will conduct a pharmaceutical manufacturer revenue pass-through audit, which will include a formulary rebate review and a minimum claim dollar guarantee review. The audit will determine if PBM is complying with the contractual terms related to formulary rebates and all other pharmaceutical manufacturer revenue that PBM receives on behalf of the Customer's

utilization. Mercer will also confirm the rebates were reimbursed in a timely manner pursuant to the contract. In order to accomplish these objectives, Mercer will perform the following tasks:

- Review a copy of the prescription drug program contract between the Customer and PBM to confirm the rebate agreement, the rebate basis, how rebates were calculated, and the timing of rebate payments to the Customer.
- Request and review quarterly rebate and pharmaceutical manufacturer revenue reports from PBM for the audit period.
- Use the rebate reports as a basis for selecting the manufacturers that will be audited. Mercer will identify and audit the top 5 manufacturers during calendar year 2018. Mercer will work with PBM to confirm agreement with the manufacturer's selected for audit.
- Conduct an on-site rebate audit at PBM's facility to review the selected manufacturer contracts and pharmaceutical manufacturer revenue reports for each rebate eligible drug and validate the rebates applied and reimbursed to the Customer were, in fact, consistent with the contract terms.
- Apply the rebate information obtained through the audit to claims data information and aggregate the results. The audited results will then be compared with the actual reported results to determine PBM's reimbursement accuracy.
- Additionally, Mercer will verify that the minimum per claim dollar amount rebate allocation to the Customer was correct based on reports, invoices and credits. Mercer will then verify the timing of each reimbursement was accurate pursuant to the terms in the contract. This rebate work will include the following:
    - Request available PBM internal reports on the Customer utilization of rebated drugs
    - Determine whether the provided documentation is consistent with actual rebate payments to the Customer
    - Validate that rebates were reimbursed on or before the date agreed to.

Timing

PBM pharmacy claim audits typically take place over a 20-22 week period, largely driven by additional time required by PBM. A number of factors can affect the time it takes to complete an audit project. These include scheduling conflicts, and the cooperation of PBM. The following table illustrates a sample pharmacy audit timeline.

TASK	TIMING
1. Notify PBM of the prescription drug audit and issue scope letter which contains the data required for the audit. Request data from the Customer (paid claims total for audit period, SPD and PBM contract)	TBD

TASK	TIMING
2. The Customer, PBM and Mercer hold audit kickoff call	TBD
3. PBM provides requested data for electronic audit	Week 1
4. Mercer submits follow-up matrix to PBM for review	Week 3
5. PBM responds to Mercer's follow-up matrix	Week 4
6. Mercer submits list of claims that were identified by the electronic pricing and compliance edits to PBM	Week 10
7. PBM provides responses to electronic audit issues (PBM requires 30 days to respond to audit exceptions)	Week 13
8. Resolve outstanding audit issues	Week 12
9. Submit draft report to PBM for review and formal response	Week 15
10. Receive response to draft report from PBM (PBM requires 30 days to respond to an audit report)	Week 19
11. Produce, release and distribute final report to the Customer and PBM	Week 21
12. Meet with the Customer to discuss findings, recommendations and next steps	TBD

Medical Claims

Effective audits yield statistically significant results that are representative of the entire claims population and identify any problems affecting claims accuracy. To achieve that objective, Mercer uses a proprietary audit methodology based on a financially stratified claims sampling approach. Typically, we use this approach to conduct all of our audits, with the exception of pharmacy, which is audited at 100%.

Note that Mercer has the flexibility to perform a 100% electronic audit of medical claims, if desired. We also have the capability to identify discrete claims from the population of claims. For example, if concerns exist about certain types of claims, we recommend that consideration be given to supplementing the statistical sample with target/focused samples of specific types claims. This type of review entails auditing a non-statistically valid sample of claims to ascertain whether or not the administrator is adjudicating a specific claim type according to the terms of the Summary Plan Description.

For example, on a recent audit, our client had concerns about the administration of speech therapy claims based on a number of appeals that came to the employer. From the claim data, we extracted all claims for speech therapy and selected a random sample of 25 claims. Each claim was reviewed to determine the medical necessity of the speech therapy, and if services were approved, the amounts paid against the plan maximum. Other types of claims that could be reviewed include:

- Infertility
- High-dollar claims
- Case management
- Specific benefit provision (such as speech therapy, chiropractic and coordination of benefits)

Our statistical auditing approach results in an extrapolation of the impact of errors from the sample claim results to the entire population of claims processed over the audit time period. Because the claim sample will be statistically valid with respect to the Customer's claim population, it is possible to make statistical projections concerning the impact of errors over all claims processed over the audit time period. We recommend that the sample size be at least 200 claims and that the audit time period be no less than 12 months.

Steps for conducting the medical claims audit are described below.

Step 1: Select Claims Sample

The sampling approach that we recommend is a combined financially stratified/attribute sampling methodology. Claims from your experience are stratified by the paid benefit amount prior to the selection of the samples to get a representative sample of your claims distribution in amounts, rather than by volume. This will be used as an indicator of the accuracy of benefit payments and compliance with your current benefit plan designs. Given the application of our sampling methodology, the sample will be representative of your actual claim experience across each of
the Customer's benefit options/plans.

Claim sampling software will assign the actual strata, however, an example of typical stratification is shown below:

Pay Strata
$0 Pay Strata
$0.01 to $500
$501 to $1,500
$1,501 to $4,500
$4,501 to $8,500
$8,501 to $11, 500
$11,501 to 16,000
$16,001 to 36,000
$36, 001 to 58,000
$58,001 to 85,500
$85,501 to 125,000
$125,000 to 160,000
Greater than $160,001

Step 2: Audit Medical Claims and Conduct Exit Conference

We will evaluate the audit sample of claims in Vendors' designated service center. Each selected claim will be tested to confirm:

- Proper and consistent interpretation of the Customer's plans
- Application of fee schedules/discount provisions
- Application of internal review procedures
- Appropriateness of medical management applications
- Application of edits to prohibit payments of ineligible services, duplicate payments, and payments to ineligible claimants
- Proper coding of information
- Presence of any gaps or bottlenecks in the processing system
- Reasonableness of turnaround time
- Complete documentation of claim
- Accuracy of payment
- Proper payee
- Adequacy of claim processors' professional training and familiarity with the Customer's benefit programs
- Accurate loading of plan provisions into the Vendors' claim system

We expect to answer the majority of our questions while we are onsite. This interactive process will help us to avoid any misunderstanding in our interpretation of the Vendors' policies and procedures. We will discuss our preliminary questions about specific administrative practices and individual claim payment errors at an exit conference. This step will further ensure that our findings are accurate.

Step 3: Prepare and Present Medical Audit Report

Our report for each audit will:

- Summarize our findings of Vendors' performance results
- Summarize the operational review and the results of any optional audits/reviews
- Provide details on the claim audit results, including:
  - Statistical errors
  - Payment errors (frequency/financial impact)
  - Timeliness of payments (turnaround time)
  - Summary results by category
- Compare the audit results with expected performance and identify any discrepancies
- Present action plans recommending ways to improve service, if warranted.

We will report accuracy in three categories in comparison to industry best practices or the Customer's performance guarantee standards:

- **Claim processing accuracy –** Reflects all types of errors (e.g., overpayments, underpayments, and procedural handlings) stated as a percentage of the total number of claims, with errors divided by the total number of claims reviewed in the sample. Minimum performance expectation is 96.0%

- **Payment incidence accuracy –** Reflects the number of correct payments in the sample, regardless of the dollar impact of the error. The accuracy rate is also stated as a percentage of the total number of correct payments, divided by the total number of payments in the sample. Minimum performance expectation is 98.0%

- **Financial accuracy –** Measures the actual dollars paid correctly against the total dollars paid, stated as a percentage of the total amount of dollars paid correctly divided by the total dollars paid in the sample. Minimum performance expectation is 99.3%

Vendors are given a set amount of time to respond to the issues raised in the audit. Upon receipt of the Vendors' response, Mercer will develop a draft report for the Customer to review, while simultaneously providing a copy to the Vendor for comment. Once Vendors have supplied their response, Mercer prepares a final report for presentation to the Customer.

Claim audits typically take place over a 20-22 week period, largely driven by additional time required by Vendors. A number of factors can affect the time it takes to complete an audit project. These include scheduling conflicts, and the cooperation of Vendors. The following table illustrates a sample audit timeline.

	ACTIVITY	TIMING
	Mercer and the Customer meet to review proposal and confirm audit scope.	1
	The Customer sends authorization letter to Vendors. Mercer and the Customer contact Vendor and confirm audit timeline and request data file.	1
	Vendors furnish audit agreement if required, and Mercer reviews and coordinates with the Customer for review and approval. (Vendor may require a signed audit disclosure agreement before release of claims data to Mercer for sampling purposes).	2
	Mercer receives claims history data file from Vendors.	4
	Mercer selects claim sample and sends listing to Vendors. If selected, Mercer sends operational review questionnaire.	5
	Vendor prepares for on-site visit: • Produce hard copies of claim submissions • Obtain system security clearance for auditors • Prepare worksite for on-site visit	6-10
	Vendor returns operational questionnaire.	11

	ACTIVITY	TIMING
	On-site audit: Mercer conducts on-site audit at Vendors' designated location (estimate up to five days, two to three auditors).	12
	Vendor responds to all outstanding issues.	13
	Mercer develops draft report and sends to Vendor for review and comments.	14-15
	Mercer receives Vendors' comments and prepares final report.	16
	Final report: Mercer sends final report to the Customer and Vendor, and schedules report presentation meeting with the Customer.	TBD
	Mercer and the Customer meet to discuss results and recommendations for next steps and improvement action strategy.	--

Operational Review Process

Mercer will conduct a review of key operational components of customer service delivery, including staffing, reporting, call documentation, and quality assurance. The review will be conducted remotely and supported by a comprehensive customer service questionnaire response.

In addition to the operational assessment, a review of 25 the Customer-specific customer service calls and PBM's policies and procedures for call handling will be conducted to evaluate the overall effectiveness of PBM's delivery of customer service to the Customer plan members. The calls will be selected at random from a log provided by PBM of recorded calls handled by CSRs on the Customer team during an agreed upon period of time.

The Mercer customer service call evaluation process defines the key elements of a call, and the characteristics, both good and bad, that comprise each element, and includes independent reviews of the selected calls by both Mercer and the PBM using Mercer's proprietary Customer Service Call Quality Evaluation Form. Each of the monitored calls will be evaluated in terms of the following elements: Greeting, HIPAA, Communication/Listening, Problem Solving/Assessment, Call Integrity, Interpersonal Skills/Empathy, Courtesy, and Closing.

Each call will be scored and rated (e.g., acceptable, needs improvement and unacceptable). Once Mercer and PBM have completed the independent call evaluations, results will be compared and calls with discrepancies will be discussed during a call calibration session to reach agreement on the scoring of all calls and to identify key areas for individual or process improvements.

EXTERNAL PEER REVIEW AND QUALITY

Mercer US Health Business publishes a SOC 2, Type II report covering the security category annually. The Scope of the report is limited to core US Health Consulting only and it does not cover Government, Marketplace, H&B specific systems, any non-US locations or non-EHB

consulting services. Clients in these situations would receive no coverage from the report. Mercer as a whole, however, does not publish a SOC 2 report because the report does not apply to all Mercer lines of business.

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