Grady County Board of Commissioners
33 17th Ave NW
Cairo, GA 39827

An Equal Opportunity Employer

Solicitation Notice

Grady County Board of Commissioners is conducting a search for a Third-Party Administrator (TPA) to help evaluate and manage its employee benefit programs through a request for qualifications ("RFQ"). The purpose of this request is to select a TPA firm that will serve as an advisor to the Grady County Board of Commissioners and its administrative team regarding employee benefits, including, but not limited to, dental insurance, life insurance, self-funded health insurance cafeteria plans, or similar plans/benefits. The selected firm will provide independent advice and counsel to the Grady County Board of Commissioners to help identify and select products providing the greatest benefit for the Grady County Board of Commissioners and its employees. Interested parties should answer each of the following questions in detail and submit their response to:

John White
HR Director
Grady County Board of Commissioners
33 17th Ave NW
Cairo, GA 39827
229-377-1512
jwhite@gradyco.org

All responses must be received by **5 p.m. on April 5, 2024** in order to be considered.

The Grady County Board of Commissioners reserves the right to waive any and all guidelines herein, to waive minor irregularities, and to reject any and all RFQ's if considered to be in the best interest of the Grady County.

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RFQ Scope of the Project

The Grady County Board of Commissioners is soliciting Requests for Qualifications (RFQs) for Third Party Administrator (TPA) services. Employee Benefit Brokerage Service. Response to this solicitation must be in a sealed envelope clearly marked "RFQ Enclosed" with RFQ opening date and time shown.

Sealed RFQ's from Third-Party Administrators will be received by Grady County Board of Commissioners, at 33 17th Ave NW, Cairo GA 39827 until 5 p.m. April 5, 2024. RFQ's received after the above time will be returned unopened.

RFQ's may not be withdrawn for a period of thirty (30) days after the date of receipt of bids. Requests for Qualifications documents may be obtained at the Human Resources office of the Grady County Board of Commissioners, 33 17th Ave NW, Cairo GA 39827 through April 5th 2024.

The Grady County Board of Commissioners reserves the right to reject any or all bids; any part or parts of a bid, waive any technicalities/informalities, increase or reduce quantities, make modifications or specifications, and award any or all of the contract in a manner that is in the best interest of the Grady County Board of Commissioners.

Qualifications should be presented on the attached questionnaire. Questionnaire responses should thoroughly detail experience and qualifications in assisting similar size Employers (approximately 137 employees).

Implementation for the insurance selection should be completed before open enrollment in August 2024, with the new plan year beginning September 1st 2024.

Grady County Est. August 17, 1905
Georgia

Grady County
Schedule of Benefits

Medical – Dental – Vision – Prescription

TBR
Taylor Benefit Resource

P O Box 6580
Thomasville, GA 31758

Phone: (229) 225-9943
FAX: (229) 225-9945
888-35-CLAIM
www.tbrtpa.com

Ron Arline
Madison Street Agency

120 North Madison Street
Thomasville, Georgia 31792

Telephone (229) 228-4903

Calendar Year Maximum Benefits			
All Essential Health Benefits			Unlimited
	In Network	**Non-Network**	**Limits**
Deductible			
Individual Wellness Deductible **Total Individual Deductible**	$1,500 $1,000 $2,500	$3,000 $1,000 $4,000	
Employee + One Wellness Deductible **Total Employee + one Deductible**	$2,500 $2,000 $4,500	$5,000 $2,000 $7,000	
Family Unit Wellness Deductible **Total Family Deductible**	$4,500 $3,000 $7,500	$9,000 $3,000 $12,000	
Payment Level (unless otherwise stated)	80% / 20%	60% / 40%	
Maximum Out-of-Pocket Individual Employee + One Family Unit	 $4,000 $7,500 $12,000	 $8,000 $15,000 $24,000	

Covered Medical Expenses	In Network	Non-Network	Limits
Allergy Services			
Office Visit	$20 Copay	60% after Deductible	
Injections	$20 Copay	60% after Deductible	
Serum	$20 Copay	60% after Deductible	
Ambulance	80% after Deductible	80% after Deductible	
Ambulatory Surgical Center	80% after Deductible	60% after Deductible	
Anesthesia	80% after Deductible	60% after Deductible	
Bariatric Procedures	80% after Deductible	60% after Deductible	
Birthing Center	80% after Deductible	60% after Deductible	
Blood & Plasma	80% after Deductible	60% after Deductible	
Chiropractic Care	$20 Copay	60% after Deductible	
Clinical Trials (Patient Costs)	80% after Deductible	60% after Deductible	
Durable Medical Equipment	80% after Deductible	60% after Deductible	
Glaucoma, Cataract Surgery and Lenses	80% after Deductible	60% after Deductible	One set
Home Health Care	80% after Deductible	60% after Deductible	
Hospice Care			
Inpatient	80% after Deductible	60% after Deductible	
Outpatient	80% after Deductible	60% after Deductible	
Family Bereavement Counseling	Not Covered	Not Covered	

Covered Medical Expenses	In Network	Non-Network	Limits
Hospital			
Inpatient Treatment	80% after Deductible	60% after Deductible	
Outpatient Treatment	80% after Deductible	60% after Deductible	
Infertility Treatment	Not Covered	Not Covered	
Newborn Care	80% after Deductible	60% after Deductible	
Outpatient Diagnostic X-ray and Lab	80% after Deductible	60% after Deductible	
Emergency Rooms Services			
Emergency	$250 Copay	$250 Copay	
Non-Emergency	$600 Copay then 80% after Deductible	$600 Copay then 80% after Deductible	
Physician Office Visit			
Office Visit	$20 Copay	60% after Deductible	
Labs, X-rays	Covered under Copay		
Surgery	80% after Deductible		
Specialist Office Visit			
Office Visit	$35 Copay	60% after Deductible	
Labs, X-rays	Covered under Copay		
Surgery	80% after Deductible		
Pregnancy Expenses (Employee & Spouse Only)	80% after Deductible	60% after Deductible	Dependent daughters covered for complications only.
Preventive Care			
Well Adult Care (Employee & Spouse only)	100%	60%	
Routine Physical Exam	100%	60%	
Mammograms - must be over age 40, unless Medically Necessary	100%	60%	
Pap Smears	100%	60%	
Prostate Exam - must be over age 50, unless Medically Necessary	100%	60%	
Routine Immunizations	100%	60%	
Well Child Care	100%	60%	
Exam	100%	60%	
Immunizations	100%	60%	
Private Duty Nursing	Not Covered	Not Covered	
Prosthetics, Supplies and Surgical Dressings	80% after Deductible	60% after Deductible	
Psychiatric Expenses			
Residential Treatment	80% after Deductible	60% after Deductible	
Inpatient Treatment	80% after Deductible	60% after Deductible	
Partial Day Program	80% after Deductible	60% after Deductible	
Outpatient Physician	$20 Copay	60% after Deductible	
Second Surgical Opinions	80% after Deductible	60% after Deductible	
Skilled Nursing Facility	80% after Deductible	60% after Deductible	Within 14 days of a 3 day stay.

Covered Medical Expenses	In Network	Non-Network	Limits
Substance Abuse Benefits			
Residential Treatment	80% after Deductible	60% after Deductible	
Inpatient Treatment	80% after Deductible	60% after Deductible	
Partial Day Program	80% after Deductible	60% after Deductible	
Outpatient Physician	$20 Copay	60% after Deductible	
Surgery	80% after Deductible	60% after Deductible	
Temporomandibular Joint Disorder (TMJ)	80% after Deductible	60% after Deductible	
Therapy			
Chemotherapy	80% after Deductible	60% after Deductible	
Occupational Therapy	$20 Copay	60% after Deductible	
Physical Therapy	$20 Copay	60% after Deductible	
Radiation Therapy	80% after Deductible	60% after Deductible	
Respiration Therapy	80% after Deductible	60% after Deductible	
Speech Therapy	$20 Copay	60% after Deductible	
Transplants *Has Separate Transplant Policy*	Not Covered	Not Covered	
Urgent Care	$60 copay	60% after Deductible	
All Other Covered Services	80% after Deductible	60% after Deductible	

Renal Dialysis Services

The member's first 41 renal dialysis visits, cumulative and not subject to annual reset, are subject to deductible and coinsurance. Additional visits are paid at 125% of the Medicare allowable amount.

Medicare Part B Reimbursement

If you or your covered dependent has End-Stage Renal Disease ("ESRD"), the Plan's medical programs primary status applies during the first 30 months of dialysis, or the first 30 months of treatment in connection with a transplant. Thereafter, Medicare generally becomes the primary payer of benefits. The Medicare Secondary Payer statute requires the Plan to identify members in the Plan, including eligible dependents, who are eligible for Medicare, including those eligible based on ESRD. To ensure the correct coordination of claims payments, members are required to provide the Plan the basis for their eligibility to Medicare (age, ESRD, or disability) and the effective date of Medicare Part A and Part B. During this period where the Plan has primary status, Medicare Part B monthly premiums for covered members and their dependents that have become entitled, including dually entitled, to Medicare based on ESRD, will be covered by the Plan, up to a lifetime maximum amount of $5,500. Reimbursement for monies withheld by Medicare from Social Security, Railroad Retirement, or Office of Personnel Management payments will be made at the end of each calendar quarter.

DENTAL BENEFITS

Deductible per Participant	$50
Maximum benefit per Calendar Year for Class 1, 2, and 3 Services	$2,000
Maximum Lifetime benefit for Class 4 Services	$1,000
Class 1 Services (Preventive)	100%
Class 2 Services (Basic)	80%
Class 3 Services (Major) Note: There is a 6 Month waiting period for Major Services	50%
Class 4 Services (Orthodontia) up to age 26 (12 month waiting period)	50%

Dental and Orthodontic Expense Benefits are separate from and in addition to the Medical Benefits of this Plan. These benefits are available only if elected by an Eligible Employee for himself/herself and Eligible Dependents. The Deductible amount, if any, which is listed above, is the amount each Participant must pay each Calendar Year toward Covered Expenses. Once the Deductible is satisfied, additional Covered Expenses will be reimbursed according to the percentages set forth above, subject to the limitations and exclusions set forth in this Article.

Covered Expenses

The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Summary of Benefits. Charges must be for services and supplies customarily employed for treatment of the dental condition, and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to Usual and Customary fees

- **Class 1 Services (Preventive)**

1. Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), but not more than once each in any period of 6 months;
2. Periapical x-rays, as required, and bitewing x-rays once in any period of 6 months;
3. Sealants for Dependent Children under age 18, but not more than once in any period of once per tooth per lifetime;
4. Topical application of fluoride for Dependent Children under age 18, but not more than once in any period of 12 consecutive months;
5. Space maintainers (not made of precious metals) that replace prematurely lost teeth for Dependent Children under age 18. No payment will be made for duplicate space maintainers;
6. Palliative emergency treatment of an acute condition requiring immediate care; and
7. Full mouth x-rays, but not more than once in any period of 36 consecutive months.

- **Class 2 Services (Basic)**

1. All Medically Necessary x-rays;
2. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible;
3. Simple extractions;
4. Endodontics, including pulpotomy, direct pulp capping and root canal treatment;
5. Anesthetic services, except local infiltration or block anesthetics, performed by, or under the direct personal supervision of, and billed for by a Dentist, other than the operating Dentist or his or her assistant;
6. Periodontal examinations, treatment and Surgery;
7. Consultations; and
8. Oral surgery

- **Class 3 Services (Major)**

  Prosthodontic services (initial installation or replacement of bridgework or dentures) will be covered only when a Participant has been covered continuously for at least 6 months, unless otherwise required by applicable law.

  1. Inlays, gold fillings, crowns, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth;
  2. Repair or recementing of crowns, inlays, bridgework or dentures and relining of dentures;
  3. Unless otherwise required by applicable law, replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:
     a. Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable; or
     b. Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months;
  4. Periodontal scaling;
  5. Re lines;
  6. Post and core; and
  7. Stainless steel crowns.

- **Class 4 (Orthodontia)**

  Orthodontic services will be eligible only when provided to covered members who are under age 26 when treatment is received and who has been covered continuously for 12 months.

  1. Preliminary study, including cephalometric radiograph, diagnostic casts and treatment plan;
  2. Interceptive, interventive or preventive orthodontic services;
  3. Fixed and removable appliance placement, and active treatment per month after the first month;
  4. Extractions in connection with orthodontic services

VISION BENEFITS

Covered Vision Expenses	
Copayment	$0
	Benefits
Calendar Year Maximum	$400 Payable at 100%
Eye Exam – not included in calendar year maximum	*once per 12 Months*
Frames	*once per 12 Months*
Lens	*once per 12 Months*
Contact Lens	*once per 12 Months*

PRESCRIPTION DRUG BENEFITS

Covered Prescription Drug Expenses	
Pharmacy Option: 30 days supply	
Copayment, per prescription or refill, for generic	$10 Copay
Copayment, per prescription or refill, for formulary name brands	$35 Copay
For a covered brand name drug where a generic equivalent is available, the member will pay the brand copay, plus the difference in the cost between the brand drug and its generic equivalent.	
Copayment, per prescription or refill, for non-formulary name brands	$120 Copay
Copayment, per prescription or refill, for Specialty	$300 Copay
Mail Order Option: 90 days supply	
Copayment, per prescription or refill, for generic	$25 Copay
Copayment, per prescription or refill, for formulary name brands[7]	$87.50Copay
Copayment, per prescription or refill, for non-formulary name brands	$300 Copay
Copayment, per prescription or refill, for Specialty	$600 Copay

I. Firm Information and Background

A. Name of Company (TPA):
B. Principal local business address of the company as well as additional locations:
C. Phone Number:
D. Fax Number:
E. When was the company established:
F. Give us some background on your company:

G. Please provide, *in detail,* all employee benefit services offered by your firm and how long you have provided each.

H. What experience does your company have in providing benefit services to similar clients?

1. References:

I. Identify the person and/or persons who will be assigned to this account. Please include titles and primary responsibilities of each.

J. List other vendors which your company has an affiliated business relationship, and how the benefit evaluation, selection and implementation process would be managed under your firm's guidance.

K. Legal name of business entity.

L. Names and addresses of all owners, shareholders, members, partners, or others with an ownership interest in the company.

II. Benefit Services

A. Customer Service:

1. What is the company's Internet web address?
2. Do customer service representatives have e-mail?
3. Do customer service representatives have voice mail?
4. Do you outsource any advisory services? If so, describe the nature and scope of services outsourced.

B. Insurance Plan Selection and Monitoring:

1. What is your philosophy concerning insurance recommendations to clients?
2. What makes your firm's benefit selection process unique?

C. Provider Selection and Monitoring

1. Are there restrictions regarding employee benefits with which you can administer?
2. Will your compensation be the same regardless of any provider we may choose in the market?
3. What specific results should we expect to achieve at the conclusion of your process?
4. How do you protect against conflicts of interest?
5. Is your company currently responsible for administration of IRC Section 125 plans (cafeteria plans)? If so, please explain how the plan is managed, administered, communicated, and how the plan document is maintained and updated

D. Education and Technology

1. Describe the philosophy your firm uses in educating employees in employee benefit plans.
2. What technology solutions can your company offer to improve the results of our benefit plans?
3. How many lives does your office have covered under any online enrollment/management systems? Is this system managed by your firm or an outside firm? Is this system an independent system, or is it connected to an insurance provider?

III. Fees and Compensation

A. Describe fees associated with your services, and separately state fees related to insurance plan selection, plan enrollment and implementation, ongoing administration of plans, flexible spending accounts, employee materials, websites and electronic benefits management systems.

B. How will all plan fees be disclosed/reported to the client?

IV. Legal

A. Has there been any litigation against your firm in the last five years related to the proviso of Employee Benefit services? If so, please explain.

B. Has any member of your firm ever been fined or suspended by the Department of Insurance or any other regulatory body in relation to Employee Benefit consulting services?