

# CITY OF CONWAY

1201 Oak Street  
Conway, Arkansas 72032

## Invitation and Bid 2010-40

### INVITATION

#### TO THE VENDOR ADDRESSED:

Bidders are invited to furnish the items listed herein in accordance with the terms and conditions attached. Sealed bids must be in the hands of the Mayor not later than November 1, 2010 at 10:00 a.m. at which time all bids will be opened and read. Unsigned bids will be rejected. Successful bidders will receive purchase order(s) within 30 days after the opening date shown above.

## SPECIFICATIONS FOR HEALTH, DENTAL and LIFE/AD&D INSURANCE

### 1. INSTRUCTIONS

- a. All bids must be submitted on the form provided. The bid must also include the specifications, as written by the City.
- b. Any exceptions from the specification shall be listed on a separate page marked "Exceptions". Supporting documents must be submitted for each exception and included with the "Exceptions" section.
- c. Failure to provide supporting evidence to each exception will nullify the said exception.
- d. Any deviation from the specifications in the actual review of the product bid, and not declared as such, will result in the disqualification of the vendor's bid

### 2. SUBMISSION OF A SAMPLE

n/a

### 3. PRODUCT LITERATURE

- a. The bidder shall submit product literature with the bid.

### 4. SUPPORTING DOCUMENTS

The bidder shall include in its bid all evidence and documentation supporting the conformity of the product with the herewith specifications which is not printed on the brochures or catalogues mentioned in paragraph 3.

## SPECIFICATIONS FOR HEALTH, DENTAL and LIFE/AD&D INSURANCE

### 1. General

The Health, Dental and Life/AD&D Insurance shall be designed to contain the Information listed by Benefit Category for Health Option #1A & 1B, Health Option #2, Health Option #3, Dental Option #1A & #1B, Life/AD&D Option #1.

All bids for health and dental coverage must include the following: Monthly premium cost for employee only, employee plus spouse, employee plus children and employee plus family.

All bids for health and dental coverage must include COBRA administration for the health and dental benefits.

Benefits must include Essential Benefits specified by Healthcare Reform.

### 2. MATERIAL

All vendors will furnish a complete exhibit of plan material (booklets, certificates Application forms, etc.) present administrative expenses and retention including commissions, etc.

### 3. Construction – n/a

### 4. Performance Specifications

**The City reserves the right to waive minor technicalities and to accept any proposal less broker and/or broker's fees and deal directly with the vendor.**

Vendors may submit multiple proposals. The City reserves the right to accept or decline all options submitted.

All proposals must include a detailed listing of any and all cost/charges for all administrative fees and/or broker fees and any other charges.

All vendors will furnish the renewal formula for the second year if the experience rating remains the same. The exhibit will include all administrative expenses and retention including commissions, etc.

All vendors will furnish their latest preferred provider directory or other listing of contracted physicians, specialists, hospitals and other medical facilities if applicable.

All vendors will furnish their present premium trends with inflation for renewal for the past five (5) years.

All vendors will provide the office address of the facility that will process claims for the City of Conway

All vendors will describe the type of technology/websites they have available to the City of Conway and the City's employees.

All vendors will provide the name(s), titles, office address and telephone contact (other than a 1-800 customer service number) of the representative(s) who will serve as the contact in resolving administrative issues.

The City of Conway reserves the right to make whatever investigation deemed necessary to determine the vendor is qualified to carry the terms, conditions, services and all related aspects of the offered proposals.

Benefits will be coordinated with other plans in compliance with Arkansas rules and regulations.

The successful bidder will be required to insure all benefits-eligible City of Conway employees and their eligible dependents regardless of pre-existing conditions. New employees will be eligible for coverage upon their first day of benefits-eligible employment (or within a standard period as designated by plan design).

The City of Conway will require detailed monthly invoices, sorted by department code, coverage, etc. Note: Submit a sample of all reports and billing statements your company will use in this area. Detail the exact services, which will be provided at the agency, broker, insurer and/or vendor level and the level and type of staff support that will be used.

All eligible employees are to be covered for a twelve (12) month period beginning at 12:01 a.m. on January 1, 2011. Vendors shall provide rates for this period. The City of Conway reserves the right to cancel the resulting contract with a thirty (30) day written notice.

All bidders must describe their medical management process/care coordination process.

### **Covered Persons**

All benefits-eligible employees (including those on leave) living in or out of the service area shall be covered. Benefits eligible employees are full time employees. Part-time employees are not benefits eligible.

Retirees and their eligible dependents.

Benefits eligible dependents of employees or retirees are covered until age twenty-six (26) or until they become ineligible.

### **7. Warranty**

All bidders shall include a copy of their warranty with their bids.

### **8. References**

All bidders shall demonstrate their experience in providing group insurance by furnishing a list of Arkansas municipalities and/or companies that utilize their services. The list must show at least 3 municipalities and/or companies, each having a minimum of 400 employees. The name and telephone number of a contact person at each of the references shall be provided

**City of Conway  
Bid Specifications**

**Health, Dental and Life/AD&D Insurance**

<b>Benefit Category</b>	<b>In Network Health Option #1A</b>	<b>Non-Network Health Option #1A</b>	<b>In Network Health Option #1B</b>	<b>Non-Network Health Option #1B</b>
Annual Deductible	\$500 per person per calendar year, \$1,000 max for family	\$1,500 per person per calendar year, \$3,000 max for family	\$1000 per person per calendar year, \$2,000 max for family	\$3000 per person per calendar year, \$6,000 max for family
Coinsurance /Out of Pocket Maximum (does not include annual deductible)	\$2,000 per person per calendar year, \$4,000 max for family	\$8,000 per person per calendar year, \$16,000 max for family	\$2,000 per person per calendar year, \$4,000 max for family	\$8,000 per person per calendar year, \$16,000 max for family
Physician's Office Services PCP Physician's Office Services Specialist	\$20 per visit For services rendered in clinic Outside Lab covered under Outpatient Surgery, Diagnostic and Therapeutic Services	40% after deductible	\$25 per visit For services rendered in clinic Outside Lab covered under Outpatient Surgery, Diagnostic and Therapeutic Services	40% after deductible
Preventive Health Services, as required by PPACA, including recommended screenings, counseling, Immunizations, well baby and child screenings, annual physical exams and routine GYN exams, mammograms, Pap Smears, PSA, Bone Density, colonoscopies, blood pressure, diabetes and cholesterol tests.	\$0	No benefit	\$0	No benefit
Allergy Services provided by PCP or Specialist	\$20	40% after deductible	\$25	40% after deductible
Hospital – Inpatient Stay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Health Services and Urgent Care Center Services	\$100 co-payment per visit Plus 20% coinsurance	Same as network	\$100 co-payment per visit Plus 20% coinsurance	Same as network
Ambulance Services – Emergency Only	50% after deductible Limited to \$1000 per trip	Same as Network	50% after deductible Limited to \$1000 per trip	Same as Network
Air Ambulance Services – Emergency Only	50% after deductible Limited to \$5000 per trip, one trip max annually	Same as Network	50% after deductible Limited to \$5000 per trip, one trip max annually	Same as Network
Outpatient Diagnostic Services – Lab and X-ray (services and procedures performed outside PCP office)	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible
Advanced Diagnostic Imaging Services – CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible
Maternity Services* Prenatal and Postnatal outpatient care (Office visit Copayment may apply first visit only)	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible
Inpatient Maternity Services (Subject to all Inpatient Deductible and Coinsurance)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Infertility Counseling or Testing Infertility Treatment not covered	50%	Not covered	50%	Not covered
*Out of Network newborn coverage limited to \$2000 per Member for all services (first 90 days of birth)				
Inpatient Rehabilitation Facility Services (limited to 60 days per member per contract year and subject to Inpatient Hospital Deductible and Coinsurance)	20% after deductible	Not Covered	20% after deductible	Not Covered
Outpatient Rehabilitation Services: Physical, Occupational and Speech Therapy; and Chiropractic Services (Limited to 30 aggregate visits per Member per Contract Year)	\$20 per visit plus 20% coinsurance	Not covered	\$25 per visit plus 20% coinsurance	Not covered
Cardiac Rehabilitation (limited to 36 visits per Member per Contract Year)	\$20 per visit plus 20% coinsurance	Not covered	\$25 per visit plus 20% coinsurance	Not covered
Mental Health & Substance Abuse Services – Inpatient Hospital* - Semi-private room	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Mental Health & Substance Abuse Services – Inpatient Hospital* - Semi-private room	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Mental Health & Substance Abuse Services – Partial Hospitalization*	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Mental Health & Substance Abuse Services – Outpatient*	\$20	40% after deductible	\$25	40% after deductible
Durable Medical Equipment (DME) and Medical Supplies,	50%	50% after deductible	50%	50% after deductible
Prosthetic and Orthotic Devices	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Diabetic Supplies, shoes (per Medicare guidelines) and equipment	20%	40% after deductible	20%	40% after deductible
Diabetic Self management Training Single Visit or Multiple visits	\$25 per program	40% after deductible	\$25 per program	40% after deductible
Skilled Nursing Facility (Limited to 60 days per Member Per Contract Year)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Home Health Care Maximum of 50 visits per year	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Hospice Care	20% after deductible	Not covered	20% after deductible	Not covered
Dental Care Services – Damage to non-diseased teeth due to accident (subject to \$2,000 per Member per accident)	Applicable Copayment 20% after deductible	40% after deductible	Applicable Copayment 20% after deductible	40% after deductible
Reconstructive Surgery – Correct defects due to Accident or Surgery. Children age 12 years and under for specific conditions. (Defects that could have been corrected prior to coverage are not covered)	50%	Not Covered	50%	Not Covered

Medications – Hospital or Ambulatory Surgical Center	Applicable Copayment 20% after deductible	40% after deductible	Applicable Copayment 20% after deductible	40% after deductible
Medications – Physician's Office	Applicable Copayment 20% after copayment	40% after deductible	Applicable Copayment 20% after copayment	40% after deductible
Prescription Drugs Cost per 34 day supply	\$7 – Generic \$25 - Brand Name – Preferred \$50 - Brand Name – Non Preferred	Not covered	\$7 – Generic \$25 - Brand Name – Preferred \$50 - Brand Name – Non Preferred	Not covered
Transplantation Services	20% after deductible	Not covered	20% after deductible	Not covered
Eye Examinations	\$20 per person , one visit each calendar year	Not covered	\$25 per person , one visit each calendar year	Not covered
Employee Assistance Program	No benefit	n/a	No benefit	n/a
Hospitals	Conway Regional Medical Center List all other Arkansas Hospitals covered In- Network		Conway Regional Medical Center List all other Arkansas Hospitals covered In- Network	

**City of Conway  
Bid Specifications  
Health, Dental and Life/AD&D Insurance**

<b>Benefit Category</b>	<b>In Network Health Option #2</b>	<b>Non-Network Health Option #2</b>	<b>In Network Health Option #3</b>	<b>Non-Network Health Option #3</b>
Annual Deductible	\$1000 per person per calendar year, \$2,000 max for family	\$1,500 per person per calendar year, \$3,000 max for family	\$750 per person per calendar year, \$1,500 max for family	\$1,500 per person per calendar year, \$3,000 max for family
Coinsurance /Out of Pocket Maximum (does not include annual deductible)	\$2,000 per person per calendar year, \$4,000 max for family	\$8,000 per person per calendar year, \$16,000 max for family	\$2,000 per person per calendar year, \$4,000 max for family	\$8,000 per person per calendar year, \$16,000 max for family
Physician's Office Services PCP Physician's Office Services Specialist	\$25 per visit For services rendered in clinic Outside Lab covered under Outpatient Surgery, Diagnostic and Therapeutic Services	40% after deductible	\$25 per visit For services rendered in clinic Outside Lab covered under Outpatient Surgery, Diagnostic and Therapeutic Services	40% after deductible
Preventive Health Services, as required by <b>PPACA</b> , including recommended screenings, counseling, Immunizations, well baby and child screenings, annual physical exams and routine GYN exams, mammograms, Pap Smears, PSA, Bone Density, colonoscopies, blood pressure, diabetes and cholesterol tests.	\$0	No benefit	\$0	No benefit
Allergy Services provided by PCP or Specialist	\$20	40% after deductible	\$25	40% after deductible
Hospital – Inpatient Stay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Health Services and Urgent Care Center Services	\$100 co-payment per visit Plus 20% coinsurance	Same as network	\$100 co-payment per visit Plus 20% coinsurance	Same as network
Ambulance Services – Emergency Only	50% after deductible Limited to \$1000 per trip	Same as Network	50% after deductible Limited to \$1000 per trip	Same as Network
Air Ambulance Services – Emergency Only	50% after deductible Limited to \$5000 per trip, one trip max annually	Same as Network	50% after deductible Limited to \$5000 per trip, one trip max annually	Same as Network
Outpatient Diagnostic Services – Lab and X-ray (services and procedures performed outside PCP office)	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible
Advanced Diagnostic Imaging Services – CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible
Maternity Services* Prenatal and Postnatal outpatient care (Office visit Copayment may apply first visit only)	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible
Inpatient Maternity Services (Subject to all Inpatient Deductible and Coinsurance)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Infertility Counseling or Testing Infertility Treatment not covered	50%	Not covered	50%	Not covered
*Out of Network newborn coverage limited to \$2000 per Member for all services (first 90 days of birth)				
Inpatient Rehabilitation Facility Services (limited to 60 days per member per contract year and subject to Inpatient Hospital Deductible and Coinsurance)	20% after deductible	Not Covered	20% after deductible	Not Covered
Outpatient Rehabilitation Services: Physical, Occupational and Speech Therapy; and Chiropractic Services (Limited to 30 aggregate visits per Member per Contract Year)	\$25 per visit plus 20% coinsurance	Not covered	\$25 per visit plus 20% coinsurance	Not covered
Cardiac Rehabilitation (limited to 36 visits per Member per Contract Year)	\$25 per visit plus 20% coinsurance	Not covered	\$25 per visit plus 20% coinsurance	Not covered
Mental Health & Substance Abuse Services – Inpatient Hospital* - Semi-private room	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Mental Health & Substance Abuse Services – Inpatient Hospital* - Semi-private room	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Mental Health & Substance Abuse Services – Partial Hospitalization*	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Mental Health & Substance Abuse Services – Outpatient*	\$25	40% after deductible	\$25	40% after deductible
Durable Medical Equipment (DME) and Medical Supplies,	50%	50% after deductible	50%	50% after deductible

Prosthetic and Orthotic Devices	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Diabetic Supplies, shoes (per Medicare guidelines) and equipment	20%	40% after deductible	20%	40% after deductible
Diabetic Self management Training Single Visit or Multiple visits	\$25 per program	40% after deductible	\$25 per program	40% after deductible
Skilled Nursing Facility (Limited to 60 days per Member Per Contract Year)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Home Health Care Maximum of 50 visits per year	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Hospice Care	20% after deductible	Not covered	20% after deductible	Not covered
Dental Care Services – Damage to non-diseased teeth due to accident (subject to \$2,000 per Member per accident)	Applicable Copayment 20% after deductible	40% after deductible	Applicable Copayment 20% after deductible	40% after deductible
Reconstructive Surgery – Correct defects due to Accident or Surgery. Children age 12 years and under for specific conditions. (Defects that could have been corrected prior to coverage are not covered)	50%	Not Covered	50%	Not Covered
Medications – Hospital or Ambulatory Surgical Center	Applicable Copayment 20% after deductible	40% after deductible	Applicable Copayment 20% after deductible	40% after deductible
Medications – Physician’s Office	Applicable Copayment 20% after copayment	40% after deductible	Applicable Copayment 20% after copayment	40% after deductible
Prescription Drugs Cost per 34 day supply	\$7 – Generic \$25 - Brand Name – Preferred \$50 - Brand Name – Non Preferred	Not covered	\$7 – Generic \$25 - Brand Name – Preferred \$50 - Brand Name – Non Preferred	Not covered
Transplantation Services	20% after deductible	Not covered	20% after deductible	Not covered
Eye Examinations	\$20 per person , one visit each calendar year	Not covered	\$25 per person , one visit each calendar year	Not covered
Employee Assistance Program	No benefit	n/a	No benefit	n/a
Hospitals	Conway Regional Medical Center List all other Arkansas Hospitals covered In-Network		Conway Regional Medical Center List all other Arkansas Hospitals covered In-Network	

**City of Conway  
Bid Specifications  
Health, Dental and Life/AD&D Insurance**

<b>Benefit Category</b>	<b>In Network Health Option #4</b>	<b>Non-Network Health Option #4</b>
Annual Deductible	\$500 per person per calendar year, \$1,000 max for family	\$1,500 per person per calendar year, \$3,000 max for family
Coinsurance /Out of Pocket Maximum (does not include annual deductible)	\$2,000 per person per calendar year, \$4,000 max for family	\$8,000 per person per calendar year, \$16,000 max for family
Physician's Office Services PCP Physician's Office Services Specialist	\$20 per visit For services rendered in clinic Outside Lab covered under Outpatient Surgery, Diagnostic and Therapeutic Services	40% after deductible
Preventive Health Services, as required by <b>PPACA</b> , including recommended screenings, counseling, Immunizations, well baby and child screenings, annual physical exams and routine GYN exams, mammograms, Pap Smears, PSA, Bone Density, colonoscopies, blood pressure, diabetes and cholesterol tests.	\$0	No benefit
Allergy Services provided by PCP or Specialist	\$20	40% after deductible
Hospital – Inpatient Stay	20% after deductible	40% after deductible
Emergency Health Services and Urgent Care Center Services	\$100 co-payment per visit Plus 20% coinsurance	Same as network
Ambulance Services – Emergency Only	50% after deductible Limited to \$1000 per trip	Same as Network
Air Ambulance Services – Emergency Only	50% after deductible Limited to \$5000 per trip, one trip max annually	Same as Network
Outpatient Diagnostic Services – Lab and X-ray (services and procedures performed outside PCP office)	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible
Advanced Diagnostic Imaging Services – CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible
Maternity Services* Prenatal and Postnatal outpatient care (Office visit Copayment may apply first visit only)	Applicable Copayment 20% after deductible	Applicable Copayment 40% after deductible
Inpatient Maternity Services (Subject to all Inpatient Deductible and Coinsurance)	20% after deductible	40% after deductible
Infertility Counseling or Testing Infertility Treatment not covered	50%	Not covered
*Out of Network newborn coverage limited to \$2000 per Member for all services (first 90 days of birth)		
Inpatient Rehabilitation Facility Services (limited to 60 days per member per contract year and subject to	20% after deductible	Not Covered

Inpatient Hospital Deductible and Coinsurance)		
Outpatient Rehabilitation Services: Physical, Occupational and Speech Therapy; and Chiropractic Services (Limited to 30 aggregate visits per Member per Contract Year)	\$20 per visit plus 20% coinsurance	Not covered
Cardiac Rehabilitation (limited to 36 visits per Member per Contract Year)	\$20 per visit plus 20% coinsurance	Not covered
Mental Health & Substance Abuse Services – Inpatient Hospital* - Semi-private room	20% after deductible	40% after deductible
Mental Health & Substance Abuse Services – Inpatient Hospital* - Semi-private room	20% after deductible	40% after deductible
Mental Health & Substance Abuse Services – Partial Hospitalization*	20% after deductible	40% after deductible
Mental Health & Substance Abuse Services – Outpatient*	\$20	40% after deductible
Durable Medical Equipment (DME) and Medical Supplies,	50%	50% after deductible
Prosthetic and Orthotic Devices	20% after deductible	40% after deductible
Diabetic Supplies, shoes (per Medicare guidelines) and equipment	20%	40% after deductible
Diabetic Self management Training Single Visit or Multiple visits	\$25 per program	40% after deductible
Skilled Nursing Facility (Limited to 60 days per Member Per Contract Year)	20% after deductible	40% after deductible
Home Health Care Maximum of 50 visits per year	20% after deductible	40% after deductible
Hospice Care	20% after deductible	Not covered
Dental Care Services – Damage to non-diseased teeth due to accident (subject to \$2,000 per Member per accident)	Applicable Copayment 20% after deductible	40% after deductible
Reconstructive Surgery – Correct defects due to Accident or Surgery. Children age 12 years and under for specific conditions. (Defects that could have been corrected prior to coverage are not covered)	50%	Not Covered
Medications – Hospital or Ambulatory Surgical Center	Applicable Copayment 20% after deductible	40% after deductible
Medications – Physician's Office	Applicable Copayment 20% after copayment	40% after deductible
Prescription Drugs Cost per 34 day supply	\$7 – Generic \$25 - Brand Name – Preferred \$50 - Brand Name – Non Preferred	Not covered
Transplantation Services	20% after deductible	Not covered
Eye Examinations	\$20 per person , one visit each calendar year	Not covered
Employee Assistance Program	No benefit	n/a
Hospitals	Conway Regional Medical Center List all other Arkansas Hospitals covered In- Network	

**City of Conway  
Bid Specifications  
Health, Dental and Life/AD&D Insurance**

<b>Benefit Category</b>	<b>In Network Dental Option #1A</b>	<b>In Network Dental Option #1B</b>
Annual Deductible	\$50 per person for benefits received in coverage B and C No deductible on coverage A	\$25 per person for benefits received in coverage B and C No Deductible on coverage A
Annual Maximum	\$1000 per person per calendar year	\$1500 per person per calendar year
<b>Coverage A – Diagnostic and Preventative Services</b> Routine periodic examinations, twice per benefit period, inclusive of initial oral exam Bitewing and periapical X-rays as required. Full-mouth X-rays once in any three (3) year period. Prophylaxis (cleaning) max of twice per benefit period. Topical application of fluoride once per benefit period for dependent children to age 19. Sealants once per tooth on permanent maxillary and mandibular first and second molars with no caries (decay) on the occlusal surface, for dependent children up to age 19.	100%	100%
<b>Coverage B – Basic Restorative Services</b> Minor emergency treatment for relief of pain as needed by participant. Amalgam (silver) and composite/resin (white) fillings (composites are not a covered benefit on molars). Endodontics, including pulpal therapy and root canal filling. Simple extractions. Oral surgery, including pre- and post-operative care and surgical extractions, except TMJ surgery. Space maintainers for prematurely lost teeth of eligible dependent children 16 years of age and under. Stainless steel crowns used as a restoration to natural teeth for dependent children to age 16 when the teeth cannot be restored with a filling material. Nonsurgical periodontics. Periodontal maintenance; two (2) per benefit period following active periodontal treatment	80% after deductible	80% after deductible
<b>Coverage C – Major Restorative Services</b> (12 -month wait for Late Entrants) Crowns, inlays, onlays, and veneers are benefits for the treatment of visible decay and fractures of tooth structure when teeth are so badly damaged they cannot be restored with amalgam or composite restorations. Prosthodontics, including procedures for construction of fixed bridges, partial or complete dentures, and repair of fixed bridges. Complete or partial denture relines, including chair side or laboratory procedures to improve the fit of the appliance to the tissue. Complete or partial denture rebase, including laboratory replacement of the acrylic base of the appliance. Surgical periodontics, Implants	50% after deductible	50% after deductible
<b>Coverage D - Orthodontic Services</b> Diagnostic, Active, Retention Treatment for eligible dependent children under age 19	50% after deductible \$1000 Lifetime Maximum	50% after deductible \$1000 Lifetime Maximum
<b>Calendar Year Maximum Rollover Benefit</b> Allows a rollover of a portion of unused dental benefits from year to year Accumulated benefit dollars may be used to help offset higher out-of-pocket costs for complex procedures.	Receive one covered dental service during the calendar year An active plan member as of December 31 Total claims paid for the year do not exceed \$500 (Yearly Threshold Amount) Total rollover balance has not exceeded \$1,000 (the Accumulated Rollover Maximum)	Receive one covered dental service during the calendar year An active plan member as of December 31 Total claims paid for the year do not exceed \$700 (Yearly Threshold Amount) Total rollover balance has not exceeded \$1,250 (the Accumulated Rollover Maximum)

**City of Conway  
Bid Specifications  
Health, Dental and Life/AD&D Insurance**

<b>Benefit Category</b>	<b>Employee Life Option #1</b>
Term Life – AD & D Guaranteed issue. Upon attainment of age 65 the amount of life and AD&D insurance shall be reduced by 35%. Upon the attainment of age 70 insurance shall be reduced an additional 15 percent to 50 percent of the original amount. Upon retirement all life and AD&D benefits shall terminate.	\$10,000

For further information regarding specifics of the Health, Dental and Life/AD&D Insurance contact Lisa Mabry-Williams, Human Resources Director, 501- 450-7087, this bid shall be submitted no later than the referenced date to:

Office of the Mayor  
Attention: Felicia Rogers  
Conway City Hall  
1201 Oak Street  
Conway, AR 72032  
(501) 450-6110

The bid shall be enclosed in a sealed envelope with the name of bidder, bid number, item(s) being bid and date and hour of opening thereon.

BID	
TO THE MAYOR:	
We hereby agree to furnish the items quoted at price set opposite each item. We further certify that we have read the terms and conditions stated on the reverse side of this page and that our quotation is submitted in accordance therewith.	
FIRM NAME: _____	BY: _____
ADDRESS: _____	TITLE _____
_____	DATE _____

Unsigned bids will not be considered

## BIDDER SUBMITTAL FORM

<b>TTL Monthly Premium Cost</b>	<b>Health Option #1A</b>	<b>Health Option #1B</b>	<b>(dual option plan)</b>
Employee Only	_____	_____	
Employee + Spouse	_____	_____	
Employee + Children	_____	_____	
Employee + Family	_____	_____	
<b>TTL Monthly Premium Cost</b>	<b>Health Option #2</b>		
Employee Only	_____		
Employee + Spouse	_____		
Employee + Children	_____		
Employee + Family	_____		
<b>TTL Monthly Premium Cost</b>	<b>Health Option #3</b>		
Employee Only	_____		
Employee + Spouse	_____		
Employee + Children	_____		
Employee + Family	_____		
<b>TTL Monthly Premium Cost</b>	<b>Health Option #4</b>		
Employee Only	_____		
Employee + Spouse	_____		
Employee + Children	_____		
Employee + Family	_____		

Prices quoted must be held firm for sixty (60) days to allow for evaluation. Indicate specific date that prices can be held through:

\_\_\_\_\_.

Protest regarding this bid must be submitted in writing to the Human Resources Director, Lisa Mabry-Williams within five (5) working days of the opening of the bid.

## BIDDER SUBMITTAL FORM

TTL Monthly Premium Cost	Dental Option #1A	Dental Option #1B	(dual option plan)
Employee Only	_____	_____	
Employee + Spouse	_____	_____	
Employee + Children	_____	_____	
Employee + Family	_____	_____	

Prices quoted must be held firm for sixty (60) days to allow for evaluation. Indicate specific date that prices can be held through:

\_\_\_\_\_.

Protest regarding this bid must be submitted in writing to the Human Resources Director, Lisa Mabry-Williams within five (5) working days of the opening of the bid.

## BIDDER SUBMITTAL FORM

TTL Monthly Premium Cost	Life Option #1
Employee Only	_____
Employee + Spouse	_____
Employee + Children	_____
Employee + Family	_____

Prices quoted must be held firm for sixty (60) days to allow for evaluation. Indicate specific date that prices can be held through:

\_\_\_\_\_.

Protest regarding this bid must be submitted in writing to the Human Resources Director, Lisa Mabry-Williams within five (5) working days of the opening of the bid.